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ABSTRACT

Strategic and operational issues throughout the world formed the focus of the International Conference on Family Planning. The objectives of the conference were to review the accomplishments of family planning over the past decade, assess the challenges and opportunities for the 1980's, and identify means to strengthen commitment to family planning as an essential component of development. The document contains conference recommendations, the keynote speech by the chairman of the conference, and the background document which supplied the key reference points for the conference. Future strategic approaches include community participation, sensitivity toward users and potential users, increased integration of family planning with other development activities, improvement in the status of women, and an increase in men's participation in family planning. Specific program recommendations involve expanding services, strengthening management and training, offering supplies, increasing communication and education, using qualitative methods in research, and exercising caution when using incentives and disincentives. Five opening speeches and lists of the consultative group and conference participants are also included. (KC)

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Family Planning in the 1980's: Challenges and Opportunities

Report of the
International Conference on
Family Planning in the 1980's
Jakarta, Indonesia
26-30 April 1981

Co-sponsored by
the United Nations Fund
for Population Activities,
the International Planned
Parenthood Federation and
the Population Council

May 1982

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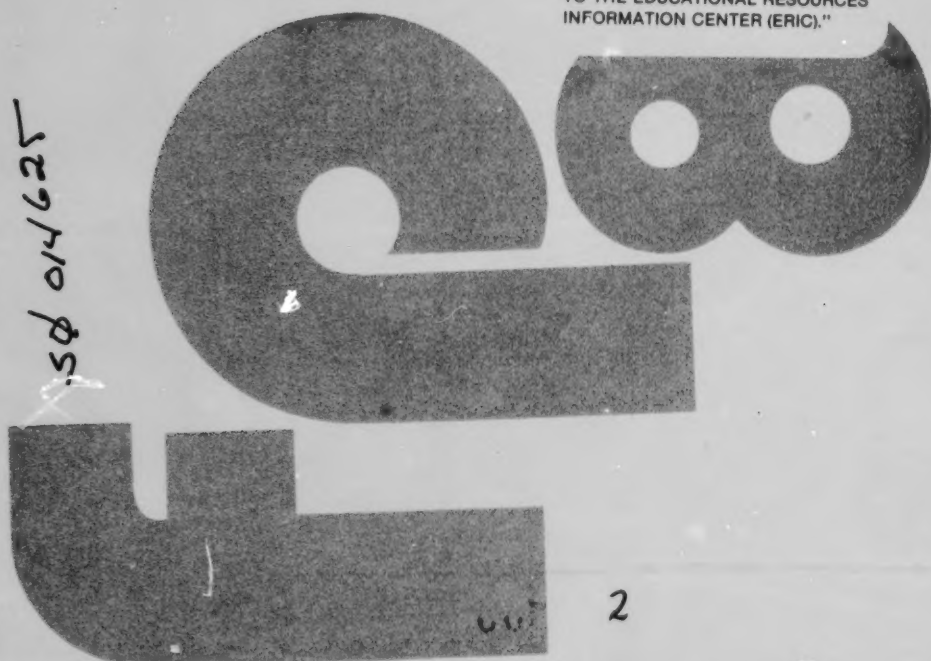
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Acknowledgements

The International Conference on Family Planning in the 1980's drew upon the resources of many individuals, institutions, and governments in its planning and implementation. It was the first international conference of its kind on family planning since 1965, and was co-sponsored by three major agencies in the population field, the United Nations Fund for Population Activities, the International Planned Parenthood Federation, and the Population Council, as well as the Government of Indonesia. The planning and organisation of such an ambitious and complex event required the concerted effort of dedicated people from all over the world. The idea for the Conference was originally conceived in early 1979 by the heads of the three sponsoring agencies, Dr. Rafael Salas, Dr. Carl Wahren, and Mr. George Zeidenstein. Members of each of the agencies formed a Steering Committee which planned and coordinated the preparations for the Conference. Members of the Committee included George F. Brown (Chairman), Jose Donayre, Muray Fincancioglu, Halvor Gille, Margaret McEvoy, Susan Perl, and Jyoti Singh. A Secretariat was established at the Population Council, with Karen Morrell as Conference Co-ordinator, assisted by Barbara Clark. The Committee met many times in New York and London, and the Secretariat provided inspired administrative support.

Two Consultative Groups were established to advise on the major issues to be addressed at the Conference: the Family Planning Consultative Group under the Chairmanship of Dr. Fred Sai and the Policy and Resources Consultative Group under the Chairmanship of Ms. Billie Miller. These Groups included leading programme planners and managers from many countries. Their invaluable insight and counsel were crucial to the success of the Conference, as it gave a variety of perspectives from all regions of the world, and added a richness and depth to the Conference that would otherwise have been lacking. The membership of these two committees is listed in this monograph.

The Background Document for the Conference was the principal resource for the Conference deliberations. The preparation of the Document was supervised by the Steering Committee, with guidance from the two Consultative Groups, which reviewed initial outlines and gave advice on the content. The Docu-

ment was written by S. Bruce Schearer and Nuray Fincancioglu, with contributions from Susan Ferl, George Brown, Barnett Baron, Margaret McEvoy, and Stephen L. Isaacs.

The Annex to the Background Document supplements the basic issues and provides a more detailed analysis of the key factors relating to family planning in the world today. It furnished a common frame of reference for discussion at the Conference. The Annex was written by Stephen Isaacs, with contributions from others as noted on page 105.

The Government of Indonesia acted as host for the Conference, and through the dedicated and efficient contributions of Dr. Suwardjono, the Minister of Health, and senior officials of the BKKBN, particularly Dr. Haryono, Dr. Pardoko, Dr. Sumbung, and their staff, provided organisational efficiency, and a warmth of hospitality that was unsurpassed. The field visits organised during and after the Conference were instrumental in providing to the Conference participants a first-hand view of one of the most effective family planning programmes in the world. The field trips were facilitated by Dr. Astawa, Dr. Cholil, and Dr. Pangestuhadi.

The Conference itself was chaired by Dr. Fred Sai, who kept the deliberations on an even keel, with intelligence, humour, and a fine sense of timing. He was assisted by Dr. Lincoln Chen as chief rapporteur, and speakers, panellists, discussion leaders, and group rapporteurs were drawn from the participants to the Conference. The Conference was truly a participatory event, with invaluable contributions by each of the 133 participants from 63 countries.

Press and publicity were efficiently organised by Michael Palmer, Susan Robbins, and John Rowley, and Frances Dennis. Valeda Slade provided invaluable editorial direction.

Financial support for the Conference was generously provided by the Australian Development Assistance Bureau, the IPPF, the Population Council, the UNFPA, and the United States Agency for International Development.

Finally, the success of the Conference was due to the vigorous and thoughtful involvement of the 133 participants, who brought with them knowledge and insight into family planning and population issues, and who made lively and vital contributions based on first-hand experience.

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**Family Planning
in the 1980's:
Challenges and
Opportunities**

Commentary

I. BACKGROUND

The International Conference on Family Planning in the 1980's was held between 26 and 30 April 1981 in Jakarta, Indonesia. It brought together 133 leaders of the family planning movement, including government and non-government representatives from 63 countries and from major international agencies.

The objectives of the Conference were to review the accomplishments of family planning over the past decade, assess the challenges and opportunities for the 1980's, and identify means to strengthen commitment to family planning as an essential component of development. As the first international conference of its kind since 1965 devoted to analysing the policy, programme, and technical issues in family planning, the Conference was of major importance. It affirmed that family planning, as an integral part of health and development, is a basic human right. In a strong final Statement, the Conference set forth principles to guide future programmes, stressing the need for community participation, sensitivity towards users and potential users, increased integration of family planning with other development activities, and improving the status of women and increasing men's participation in family planning.

II. ORGANISATION OF THE CONFERENCE

The International Conference on Family Planning in the 1980's was sponsored by the International Planned Parenthood Federation, the Population Council, and the United Nations fund for Population Activities. A Steering Committee, composed of representatives of the three sponsoring agencies, worked with two consultative groups comprised of family planning policy and programme experts, largely from the developing world, to plan the Conference.

At an early stage in preparation for the Conference, a determination was made that a Background Document which analysed the current status of family planning and examined the challenges and opportunities for the 1980's would serve the participants

better than the more traditional presentation of conference papers. During the latter part of 1980 and early 1981, the Background Document and its Annex, which examined in more depth the current status of family planning, were prepared. Both documents were reviewed by the Family Planning Consultative Group, composed of programme planners and managers from 12 developing countries. The group met twice--first to establish guidelines for the Background Document and, second, to review it in draft form; the group played an active role in determining the topics to be given priority in the documents. A Policy and Resources Consultative Group, consisting of 15 development and population planners, met once to consider policy and resource issues. Their observations were incorporated into the Background Document.

The Background Document and Annex served as the key reference points for the Conference, and were utilised throughout to guide discussion and to clarify issues. The Recommendations of the Conference flowed from the panels, working groups, and plenary sessions. Although the Conference found itself in agreement with the presentation and conclusions of the Background Document, the final Statement and Recommendations diverged in a number of ways from its suggestions. Both the Background Document and Annex are reprinted in their entirety in this volume.

The selection of Jakarta as the site of the Conference is not without symbolic significance. Indonesia is one of the success stories of family planning, a country which, in the words of Carl Wahren, Secretary General of the IPPF, "has demonstrated that with a strong national policy and the full participation of the people much progress can be made." President Suharto officially opened the Conference at the Presidential Palace. In his address to the assembled delegates, he called the success of family planning programmes "an essential key to the creation of a happy family" and stated that "successful implementation of family planning programmes will be a key to the survival of the world in the future." His address was preceded by those of Dr. Suwardjono Surjaningrat, Minister of Health and Chairman of the National Family Planning Coordinating Board of Indonesia; Dr. Rafael Salas, Executive Director of UNFPA; Dr. Wahren; and Mr. George Zeidenstein, President of the Population Council. Following the conclusion of the opening ceremony at the Presidential Palace, Dr. Fred Sai, Chairman of the Conference, gave the keynote

address. The opening speeches are also reprinted here.

Between the afternoon of 27 April and the evening of 30 April--with the exception of one day when the Conference participants were invited to take field visits in urban and rural areas around Jakarta--the Conference worked in plenary sessions and smaller working groups. Topics were divided into the headings, "strategic issues in family planning," "operational issues in family planning," and "policy commitment and resource development." At the plenary sessions, one, or in some cases, two participants made brief presentations analysing the salient issues of the topic at hand, followed by a response from several panellists and questions and comments from the floor. The working groups, composed of 15-20 people per group, met and pursued the issues in further detail. The Chief Rapporteur edited and summarised the suggestions of the plenary sessions and working groups and presented a draft series of recommendations to the final plenary session on the evening of 30 April. Members of the plenary session felt, however, that the draft recommendations were somewhat too technical and did not wholly capture the sense of political urgency felt by many of the delegates. The Conference Chairman, Dr. Sai, then appointed an ad hoc drafting committee, chaired by Dr. Attiya Inayatullah, to prepare a Conference Statement. The Jakarta Statement is a strong call to action. It states that

The challenge of the 1980's is to secure the political commitment, financial and human resources to meet the family planning needs of 900 million couples of childbearing age...

and sets forth nine actions "of profound practical and moral importance for all mankind" which must be taken to meet the challenge.

The Statement was approved by the final plenary session during the early morning of 1 May. The plenary session also agreed to the principles of the Recommendations, which tended to be more technical, and authorised the Chief Rapporteur and the Steering Committee to make the language more precise after the Conference concluded. The Recommendations and the Jakarta Statement are reprinted in this volume.

Upon conclusion of the Conference, many of the participants accepted the offer of the Indonesian Government to observe the successful family planning programme in East Java and Bali. These visits com-

plemented the field trip taken by the delegates on the second day of the Conference to observe the Indonesian family planning programme in and around Jakarta.

III. SUBSTANTIVE ISSUES

The Conference was remarkable for the degree of consensus among the delegates. Although opinions diverged about emphasis and implementation, there was agreement about the great progress made by family planning, its importance to socio-economic development, overall strategies for bringing family planning to the people, and the need for greatly increased political commitment and resources, both nationally and internationally. The areas of disagreement on substantive issues where compromise had to be actively sought involved payment of incentives to users or providers, legalisation of abortion, and integration of family planning with other development activities.

The major themes discussed at the Conference are reviewed below.

A. RATIONALES FOR FAMILY PLANNING

The right of people to decide the number and spacing of their children, a right established in United Nations resolutions and declarations dating from the mid-1960's, was ringingly reaffirmed by the Conference as the primary rationale for family planning. The Conference added that this right must be made tangible by governments adopting family planning policies and translating them into programmes that meet the needs of their own people.

The importance of family planning in improving health, particularly the health of children and mothers, was also affirmed. As Conference Chairman, Dr. Sai observed:

Those who withhold family planning education and services from individuals and couples must know that they are denying human beings the benefit of a powerful health measure.

That family planning is an important part of social and economic development was taken as a given by the Conference, which had absorbed the lessons of Bucharest and wanted to go beyond them. There was

little discussion about whether development precedes fertility decline, nor was there extended discussion about whether countries should concentrate on family planning or development. The Family Planning in the 1980's Conference rejected the dichotomy between population and development and accepted family planning as an integral and important part of any "development strategy that seeks to improve the quality of life for both individuals and communities."

The Background Document touched gingerly on the demographic importance of family planning programmes. The Conference confronted the issue more forthrightly; the Jakarta Statement talks of the responsibility to meet the needs of 900 million couples, a number that is projected to double by the year 2000, and the importance of taking action so that population can be stabilised by the twenty-first century.

Although all of these rationales for family planning were recognised by the Conference, the intensity of the endorsement tended to vary from region to region and, in some cases, from country to country. Thus, the participants from Africa and Latin America emphasised the health benefits of family planning. Participants from the more populous Asian nations and representatives of some international agencies, although not neglecting other rationales, tended to stress the importance of family planning to lower population growth rates and improve development prospects.

The Background Document mentioned two additional rationales for family planning, noting that "while these viewpoints have not received universal acceptance and, indeed, continue to be controversial, they nevertheless are considered important by some governments and institutions." The first, which links population growth and environmental degradation, was not specifically addressed. The second, relating reduced population growth to improved national security, engendered some controversy. This rationale, proposed from the floor, holds that rapid population growth and urbanisation contribute to political instability by increasing competition for scarce resources and raising unemployment; therefore, family planning is needed to alleviate these conditions. It was also proposed for inclusion in the draft of the Jakarta Statement. In both cases, it was rejected on the basis that many country-specific issues of a social and economic nature can affect national security.

The Conference gave considerable attention to the success of family planning programmes over the past decades. Governments of 118 nations have adopted policies supportive of family planning. More than 270 million couples have chosen to use contraception, about 90 million of them in developing countries. Fertility has declined in many developing nations, in some cases up to 35 percent over the past decade, and a correlation between contraceptive prevalence and fertility decline has been clearly established.

Even though successes have been achieved, the Conference stressed that the job was not complete and that there were no grounds for complacency. As Rafael Salas stated in his opening address:

Our present cautious optimism over the decline of the population growth rate from 2 percent in the sixties to the present 1.7 percent and, hopefully, 1.5 percent in the year 2000 is based on the experience of several decades of hard work. If this decline is to continue and stability is to be achieved in the middle of the twenty-first century, efforts from now up to that time must be continuous and sustained.

B. STRATEGIC ISSUES

By "Strategic Issues" are meant those that transcend specific operational considerations and that serve as general principles intended to guide action in all programme development. Four strategic issues were identified: emphasising the user's perspective, ensuring greater community participation in family planning, integrating family planning and other components of development, and improving women's status and men's participation in family planning.

1. User perspective and community participation. Many participants noted that programmes are not sufficiently responsive to the perspective of users and potential users. Despite increased contraceptive prevalence in many countries, low levels of acceptance are characteristic of many family planning programmes, perhaps reflecting a lack of demand, but also reflecting a failure to design programmes and provide services in a manner appropriate to the needs of the people. The low levels of con-

tinuation for many kinds of contraception corroborate the importance of providing services in a manner that is culturally and socially acceptable to individuals.

The importance of the user perspective and community participation was stated in the Background Document:

The major challenge for the coming decade is for family planning programmes in different cultures and political systems to find means for bringing about wide-scale involvement of local communities in their activities in ways that are compatible with local conditions and needs.

The Conference was unanimous in agreeing upon the importance of community participation and of greater emphasis on the needs and desires of users and potential users. How to achieve this was, however, the subject of considerable debate. For if the community is truly involved and if the user's perspective is truly recognised, then there are significant implications for the design and implementation of programmes.

First, services must be decentralised. As one participant stated, "Communities must not just be the object of services but also participate in the design and implementation of programmes; governments must allow villagers to make the choices about matters such as family planning which are so central to their lives." Second, it is necessary to use existing local institutions, not superimpose new ones or simply bring in services designed by outside government officials. Pandmats, banjars, village councils, and village health committees have been delegated authority to design and operate programmes with some success. Third, programme managers must develop a respect for community values and traditions, not simply reject them as old-fashioned. This is particularly true regarding attitudes of the medical and nursing communities towards traditional health practitioners and traditional birth attendants. The Conference agreed that the person who is responsible for the health of the community generally should also be responsible for the community's reproductive health. Relating to this, managers must be given a kind of training that will enable them to communicate with villagers in a manner that is not condescending or patronising. The Conference observed that social marketing programmes should be fostered. Through these programmes, contraceptives

are made available in local stores at low subsidised prices. Since people do not generally purchase unwanted products, social marketing was seen as one way of ensuring that the needs of villagers are met.

In short, ensuring that the perspective of the user is adequately considered and that the community is truly involved in all aspects of communication and services suggests quite dramatic departures from the way many services have been offered in the past --that is, from the top down. As one working group stated, "As soon as possible maximum resources, decision-making power, and other responsibilities should be assumed by the community."

Dr. Raj Arole, who has established a successful comprehensive health and family planning programme in Jamkhed, India, summarised the sentiment of the Conference:

In order to involve the users and community-at-large, family planning workers need to undergo attitudinal changes. An in-depth review of existing programmes from the user's vantage point is urgently needed. New methods are needed to obtain information about people's perceptions regarding all aspects of family planning programmes. This kind of information is best gathered by people who are part of the community.

... Community participation, whether self-guided or externally helped, has great potential in releasing the resources and energies of ordinary citizens. If the community perceives the family planning programme as its own, then the programme has an excellent chance to succeed.

2. Integrating family planning with health and other development activities. In many countries family planning has been offered as one of a number of health services, particularly maternal and child health services. A number of participants, using the example of multipurpose community health workers as a foundation, suggested all family planning programmes be merged with, or integrated into, broader health or development activities. Other participants countered that, historically, integration of family planning into other activities has led to its dilution. They argued that many successful programmes in the health field had a singular purpose, such as malaria eradication. Some argued that caution

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should be exercised; for example, one working group reported that

The integration of family planning with health services, or its linkage with other aspects of development, should be seen more as country specific and community specific than as a clearly definable goal that can be achieved universally.

The majority sentiment of the Conference favoured an integrated approach, and the Recommendations stated that family planning should be linked with other development efforts. The concerns about the dilution of family planning were taken into account by the statement that

Integrated approaches, however, should not lead to lower priority for family planning, nor compromise the effectiveness of existing family planning programmes.

The Conference felt that services could be integrated in two ways. First, they could be linked with other health or development programmes. More specifically, family planning could be incorporated as an essential service in primary health care programmes. This accords with the priorities of many governments and is in keeping with the Declaration of Alma Ata. The importance of incorporating family planning as part of primary health care--and of other development activities--was repeated many times in working groups and in the plenary sessions.

A statement by one of the participants from the floor serves to summarise the Conference feeling on this point:

There should be an active search for use of effective, practical linking of family planning with other development activities, especially primary health care, nutrition and programmes to enhance women's status and male responsibility, as well as education, agriculture and rural development.

3. Improving women's status and increasing male participation in family planning decisions. In many countries social and economic restrictions adversely affect the status of women in society and within the family. They also strengthen cultural pressures for

women to devote their full attention to their maternal roles to the exclusion of other activities.

The importance of improving the status of women, both as a valuable goal in itself and as it tends to decrease the motivation to have many children, received considerable attention at the Conference. As one participant stated, "One of the most important goals is to attain absolute equality between men and women." The Conference proposed several ways in which this goal could be reached. First, discriminatory laws and practices should be removed, particularly those that restrict the opportunities of women to gain education or employment. Changing the legal structure to reduce discrimination against women was termed by one participant "the most important single step that could be taken to improve the status of women." Second, there is a need to develop projects aimed at improving women's lives directly. Third, efforts must be made to increase women's participation in programme design and management and in formulating family planning policies. In this regard, the Conference, although not specifically recommending affirmative action programmes for women, adopted the substance of a proposal set forth at the beginning of the Conference by George Zeidenstein:

There continues to be a notable scarcity of women among the decision-making officials of family planning programmes. Yet it stands to reason that women are much more likely than men to be aware of problems experienced by female users of contraceptives, and more effective than men as personifications of family planning ideas. The only way to overcome this problem is to engage in what is called affirmative action by actively seeking out, recruiting, training, and developing potential women administrators and leaders.

The Conference also recognised that a more equitable sharing of fertility related decisions will be possible only if men recognise family planning as a joint responsibility. In many countries, fertility related decisions are made by men, yet educational and service programs have been geared only to women. Thus, in the words of Dr. Sai:

It is necessary to educate males about family planning and its importance to their lives and the lives of their children. It

is necessary to make men understand how they can help the women folk and support them in using family planning methods, and how they can take a greater responsibility in contraceptive practice.

The Conference also recognised the need for a major commitment to develop new contraceptive methods for males.

C. PROGRAMME ISSUES

Calling for a dramatic expansion of family planning information and services to meet current and expected demand, the Conference considered six areas of activity: expansion of services; management and training; contraceptive technology and supplies; communication and education; research and evaluation; and incentives and disincentives. There was widespread agreement about almost all of the programme recommendations, the notable exceptions being abortion and incentives.

1. Expansion of services. The urgent need to expand family planning services was stressed repeatedly by the Conference participants. The results of the World Fertility Survey demonstrate in country after country that women not protected by contraception want to have fewer children, results corroborated by the large number of illegally induced abortions worldwide.

The Conference emphasised that acceptance of family planning requires basic changes of attitudes and behaviour in many parts of the world; or, in the words of one participant, "tremendous social and cultural change." In this regard the Conference stressed the long-term nature of planning, and urged, in particular, that the qualitative aspects of programme development, which might bear fruit slowly, should not be sacrificed to reach higher quantitative targets in the short run. Services must be expanded and their quality improved throughout the world on a massive scale.

The consensus of the Conference was that programmes should address the full range of their clients' family planning needs, including infertility services where appropriate. The Conference took a strong stand on the need to provide services and education for adolescents, echoing the statement made in one working group:

Adolescent pregnancy is a serious problem in the developing, as well as the developed, world. It has severe social, psychological, and health repercussions. Adolescents should receive family planning education and services through appropriate channels and should be involved in the planning and implementation of population, family life, and sex education programmes.

Priority should be given, according to the Conference, to the expansion of community-based and commercial distribution efforts. Community-based distribution programmes have been initiated in nearly 40 developing countries. Subsidised commercial programmes now exist in more than 30 developing countries. As one participant observed:

We must go beyond the doctor, beyond the clinic. We must serve the people living in remote villages and urban slums. We can do this by bringing services to the people. Community agents live in the villages; they know their neighbours and are better able to serve them than outsiders. Small stores are found everywhere, even in the most isolated communities. They should be selling contraceptives as well as other products that villagers need. It is through this commercial sector that the greatest potential for expansion of services lies.

2. Management and training. The Background Document states:

Of all the factors that will determine the progress made in the field of family planning in the 1980's, none is likely to be more important than programme management.

Even though technology has improved over the past decade and programmes have been successful, effective management of programmes remains an obstacle. Although the topic of management was clearly considered important, it did not receive extended discussion, perhaps because there was such widespread consensus about its significance. Improved programme management involves many elements. Some, such as sensitivity to users, more active participation of the community, and recruiting more women for decision-making positions, have already been discus-

sed. Others that the Conference considered are examined below.

First, the sheer number of managers needed if family planning programmes are to expand will be enormous. Second, the expansion of programmes, coupled with greater decentralisation, will require new kinds of people who will be able to solve novel problems. The Conference emphasised the importance of training a new type of manager, one who will be, at the same time, highly professional in focusing on long-range priorities and realistic planning, implementation, and evaluation, as well as sensitive to the needs of the community and the user.

Second, the new manager will have to be creative in adapting programmes to local conditions and responding to community needs, particularly regarding supplies. One working group noted that "decentralised provision of family planning services and supplies creates numerous logistics problems." These problems must be addressed through a strengthening of management systems, distribution at the local level, and provision of follow-up services for clients. They must also be addressed through better planning related to logistics and supply systems, accompanied by increased training of relevant personnel.

Third, the Conference emphasised the need for simple management-information systems and for practical operations research that could assist management decisions. One working group expressed what appeared to be the consensus of the entire body:

Information systems should seek to collect information that is most useful for family planning programme managers. The system should serve to move the programme forward and should be kept as simple as possible. Small operations research projects should be carried out to give managers information on the effectiveness of different approaches and their cost.

3. Contraceptive technology and supplies. The Conference called for family planning programmes to provide a wide range of contraceptives, including conventional methods and voluntary surgical contraception, and to promote breastfeeding for both child health and spacing reasons. It also recognised the importance of developing and testing new contraceptives and improving the efficacy of existing methods.

After considerable debate, the Conference made a recommendation on abortion, which proved to be a delicate issue. It has been estimated that between 30 and 55 million abortions are performed annually. The laws of most Latin American and African countries are restrictive, while those in Asia and the developed world tend to be more permissive. The treatment of complications for incomplete abortion is a major health hazard in many parts of the world. And, of course, abortion is an issue of the highest ethical sensitivity. Given this context, it is not surprising that suggestions by some participants that abortion be made legal were not acceptable to the Conference as a whole. Agreement, however, was reached that abortion should be widely available where local laws and customs permit, and that where it is not legal, further research on the health problems of illegal abortion should be carried out.

Several working groups considered the matter of future contraceptive supplies. Participants recognised the urgent need to plan for increased supplies through the 1980's to meet rapidly expanding demand. The Conference asked donors and recipients to agree, over the next 12 months, to a joint plan of action to review the supply and purchase of contraceptive commodities for the 1980's. During the 1980's many countries will find it necessary or desirable to move from donor dependency towards greater self-reliance in terms of contraceptive supply. An orderly transition from dependency to self-reliance requires closer collaboration among donors and between donor agencies and recipients, including the continuation of supplies during the transition period and the adoption of a realistic timetable in moving towards this desirable goal. The implications of this process are not fully recognised and urgently require greater attention from both donors and individual countries.

4. Communication and education. Little disagreement surfaced concerning communication and education. The plenary address presented by Dr. Guillermo Lopez Escobar of Colombia noted a confusion in the objectives of communication activities due to the multiple purposes they fulfil (e.g., information, motivation, attitudinal change), a point also made by the Background Document and two of the working groups. Although recognising the efficacy of person-to-person communication, the Conference also emphasised the importance of using new technology.

The Conference stressed the need to intensify efforts to reach national policymakers, to make communications more sensitive to local values and concerns, and to invest much more communication effort in family life, family health, and sex education.

5. Research and evaluation. Although research and evaluation was discussed on the floor and in the working groups, it generated little disagreement. The three main points, upon which there was consensus, were that (1) qualitative evaluation should be given more importance, (2) applied operations research, useful to managers, should be given priority, and (3) more funds should be invested in contraceptive research and programme management analyses.

The mood of the Conference regarding evaluation was perhaps best expressed by one of the participants, who said:

Successful family planning is a long process over time, requiring fundamental changes in attitude and behaviour in many cases. It requires that high quality services be provided with care and sensitivity. It requires also that the quality of services be evaluated. Although service statistics are important, only by looking at qualitative aspects will fundamental questions be answered. It is important to know, for example, why high dropout rates exist, why people change methods so frequently, what cultural factors must be considered in programme development, how good is the quality of care, and so forth. Many of these questions can be answered by operational research studies. There is also an urgent need to carry out research studies which will be addressed to measuring the efficiency of family planning programmes in order to arrive at rational bases for the allocation of resources.

6. Incentives and disincentives. The use of incentives and disincentives to lower fertility has been associated largely with Asian programmes, although they have also been used to a lesser extent in other areas. The use of incentives raises important ethical, social, and political questions, which were

reflected in some fundamental disagreement at the Conference.

Some participants expressed strong feelings that incentives, particularly cash payments to users and providers, violate the human right to choose freely the number and spacing of one's children, and are, by their nature, coercive. In the words of Zafrullah Chowdhury, cash incentives "corrupt both the giver and the receiver." These participants urged the Conference to come out strongly against the use of cash incentives and, by implication, other incentives and disincentives.

Other participants, in response, argued that incentives and disincentives were compatible with their cultural and social values, that economic inducements were used to influence people's behaviour in many areas, that incentives and disincentives were an appropriate response to rapid population growth, and that although perhaps subject to the possibility of abuse, incentives and disincentives were not inherently coercive.

Faced with these conflicting viewpoints, the Conference concluded that incentives "must reflect specific country and cultural situations, reconciling individual freedom of choice and societal needs." It recommended that cash incentives to providers and users be restricted because of their potential for abuse, and urged that where incentives schemes were used, emphasis should be given to incentives which benefitted the community and society rather than particular individuals. It also recommended that pilot studies be carried out to see whether incentives really are effective.

D. COMMITMENT AND RESOURCES

The call of the Conference to increase commitment and resources to family planning flowed naturally from the discussions on strategic and programme issues. The Conference recognised that in a number of countries family planning was at least partly responsible for fertility reduction. As Dr. Salas observed in his opening address:

The developing countries have adequately demonstrated in the past ten years that, with the proper amount of external assistance and an increasing amount of investment on their part in population programmes, they have been able to moderate population growth.

The Conference felt that there now existed an understanding of what family planning is about and what makes programmes work. At the same time, demand for family planning services continues to increase.

For the first time, a wide gap exists between requests for financial assistance and the availability of funds, which had been increasing steadily until the past year but which has now started to level off. Whereas previously many countries were reluctant to initiate population and family planning programmes, the picture has dramatically changed and a shortage of funds is a fundamental and serious limitation for countries wishing to implement such programmes.

The call for increased commitment to family planning has important ramifications at both national and international levels. At the national level, the key, the Conference concluded, was greater self-reliance. This implies greater funding of family planning by national sources, greater use of resources at the community level, and a greater share of the cost borne by the consumer. The Conference specified that a goal of 5 percent of domestic government spending should be devoted to population and family planning programmes. Great emphasis was placed on establishing population policies or, where such policies exist, implementing them vigorously. In particular, this means that laws and administrative regulations that impede people's access to family planning should be revoked or modified. The role of the private sector was also stressed. In the words of the Jakarta Statement, "The non-governmental sector should be fully used to stimulate and complement government family planning programmes."

At the international level, the Conference called for greater financial commitment, particularly from the developed countries and those with positive balance of payments. The commitment should be enough, in the words of one working group, "to put family planning on a secure footing." The Conference recommended the target of \$3 billion annually, to be reached as soon as possible. This represents the combined contribution of both population assistance from developed countries (\$1 billion) and national budgets of developing countries (\$2 billion). This objective parallels the target set by the Colombo Meeting of Parliamentarians of \$1 billion in international population assistance by 1984. The Conference also called on developed countries to raise the percentage of development assis-

tance for population from the current 2 percent to 5 percent.

At both national and international levels, the Conference called for greater efforts to make population matters better known among leaders, particularly parliamentarians, to substantially increase funding for contraceptive technology, and to promote technical co-operation among the developing nations.

IV. CONCLUSION

A conference such as the International Conference on Family Planning in the 1980's has both a political and a technical purpose. The political purpose is to awaken policymakers to the importance of family planning and to create a desire in the Conference participants to renew their efforts in the field. Ultimately the success of the political purpose will be measured by increasing commitment on the part of governments and international agencies to population and family planning. The technical purpose is to review achievements to date, analyse accomplishments, and utilise the knowledge gained in improving programme planning and performance.

Although a final evaluation of the Conference's success must await future developments, it can be said that the Conference did accomplish these two purposes. The Jakarta Statement is a strong affirmation of the importance of family planning. As a political document, it reflects the view of the delegates that family planning is important, that it has been successful, and that it needs to be continued and receive greater support. This is the message that the Conference wished to be carried to governments and donor agencies around the world. The Recommendations are based on a comprehensive review of the state of the art of family planning by the working groups and plenary sessions. They pinpoint key elements responsible for successes in family planning; these include greater sensitivity to users and prospective users, increased utilisation and appreciation of community resources, more integration of family planning with health and other development activities, and improvements in the status and role of women. They also examine important programme areas -- training, management, contraceptive technology/supplies, communication and

education, research and evaluation, and incentives. The Recommendations provide a blueprint for successful family planning programmes over the next decade.

As one participant stated, "The ultimate objective is a world where individuals can develop to their full human potential in dignity and with a decent quality of life." The International Conference on Family Planning in the 1980's gave some guidance on how to reach that objective.

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Recommendations

The recommendations were published immediately following the Conference and include the Jakarta Statement.

STRATEGIC APPROACHES FOR THE 1980's

For the decade of the 1980's, the Conference identified four essential components of an overall strategic approach to family planning.

USER'S PERSPECTIVE

Family planning programmes need to tailor their services and the contraceptive methods they offer to the needs and preferences of the people who use them. Programmes should undertake the following specific actions to provide services in ways that are sensitive and responsive to local community values and individual needs.

- Employ local people and local community institutions to the maximum extent possible in the planning and provision of family planning information and services.
- Develop workable techniques for identifying local people's needs, problems, and preferences, and incorporate this information directly into the design and operations of programmes and into the evaluation of their effectiveness.
- Launch new training programmes to enable family planning programme managers and staff at all operational levels to respond more effectively to the needs of the people and communities they serve.

COMMUNITY PARTICIPATION

Family planning programmes must engage communities more actively in both the design and the actual provision of family planning information and services. Only in this way can programmes truly reflect local priorities and be accountable to the people they serve. Family planning programmes should foster community self-reliance and participation through the following actions:

- Encourage and assist existing social institutions with communities to provide family planning information and services to members of the community.

- Delegate more resources and responsibility for the design and operation of family planning services to community groups by decentralising the planning, decision-making, and management of family planning programmes.
- Involve community groups in a manner that both respects and builds upon their local values, customs, and institutions.

INTEGRATION OF SERVICES

As one important element of socio-economic development, family planning must be increasingly linked with other development efforts to meet people's needs and to advance the well-being of communities. Such integrated approaches, however, should not lead to lower priority for family planning, nor compromise the effectiveness of existing family planning programmes. The following actions are recommended:

- Offer family planning services as one component of care for the entire family; and incorporate family planning as an essential service in primary health care programmes.
- Facilitate the incorporation of health care and other social services into existing family planning programmes, where these other services are not currently available.
- Extend the range of family planning services by building upon other development activities such as education, agricultural extension, co-operatives, women's organisations, nutrition projects, and similar community-based economic and social programmes.

WOMEN'S STATUS AND MEN'S PARTICIPATION

Many existing social, cultural, and economic restrictions undermine the status of women in society and within the family, preventing their full development as individuals and limiting their ability to participate in national development. These constitute important obstacles to the adoption of family planning. At the same time, family planning contributes directly to enhancing the status of women. There is also a need to promote male participation in family planning, as well as increased practice of

contraception by men. The following actions are recommended.

- Promote improvements in the status of women by seeking changes in laws, customs, and practices that discriminate against them.
- Assist women to improve their lives by supporting special women's development programmes in education, health, nutrition, income generation, and other areas.
- Design family planning services to address inequities between men and women. To do this, programmes need to greatly increase the participation of women not only in provision of services, but also in management, policy-making, and programme design.
- Improve information and services, including development of acceptable and effective methods of contraception, to meet the needs of men and to enable them to assume a greater role in contraceptive decision-making and practice.

COMMITMENT AND RESOURCES

The Conference strongly calls for a redoubling of both national and international efforts to secure the political commitment and human and financial resources required by family planning in the 1980's. The crucial significance of family planning in improving individual well-being and in achieving social and economic advancement must be recognised. Most importantly, governments and international organisations need to substantially increase financial resources allocated to population and family planning programmes. On an average, \$1 billion, or less than 50 cents per person, is available annually for family planning services in developing countries. Another \$500 million is provided through international development assistance. However, the demand for family planning information and services far outstrips the available funds, and the gap is growing. The following actions are urgently needed:

- Increase overall national and international expenditures for population and family planning programmes to \$3 billion annually, as rapidly as possible.
- Increase substantially the proportion of public expenditures that developing countries allocate for family planning programmes to a level of approximately 5 per cent of domestic government spending. The ultimate goal should be national self-reliance.
- Increase the international assistance to population and family planning programmes from the current level of 2 per cent of development aid to at least 5 per cent. All developing countries with positive balances of payment are urged to join this effort more actively.
- Improve the cost-effectiveness of national and international resources allocated to family planning. International agencies should make stronger efforts to ensure mutual co-operation and co-ordination. Population and family planning should be incorporated into other development activities at community, national, and international levels.
- Ensure that international assistance responds to national priorities and promotes technical co-operation among developing countries. Full use should be made of the institutional and human resources within developing countries. Sustained long-term commitment of support is essential. Donor countries should ensure that multilateral assistance for family planning is made available to all developing countries that require such aid.
- Implement population and family planning policies more actively and effectively. Countries with such policies should make every possible effort to reach all segments of their populations equitably with family planning information and services. Legal and administrative barriers should be removed. Countries without such policies should urgently consider the role of family planning in fulfilling the human rights of their citizens and achieving overall development goals.
- Develop commitment to family planning among leaders at community and national levels.

Non-governmental organisations should continue to serve as leaders and pace-setters in promoting and developing policies and innovative programmes. These organisations play a crucial role in generating awareness among policy-makers and people, especially in countries where family planning is not well-known or widely practised.

- Expand worldwide efforts to create greater knowledge of population and family planning issues among parliamentarians and other government leaders.
- Increase substantially funding by governments and international agencies for research aimed at improving contraceptive technology, in view of the inadequacies of present methods. For greatest pay-off, this should be largely concentrated on applied contraceptive research.

SPECIFIC PROGRAMME RECOMMENDATIONS

Improvements in family planning programmes are influenced by numerous managerial and operational factors. The Conference recommends specific action in the areas of expanding services; strengthening management and training; improving contraceptive technology, communication and education, research and evaluation; and the use of incentives.

EXPANDING SERVICES

- Greater access to and availability of family planning services needs to be achieved, particularly among disadvantaged and less accessible populations. Innovative approaches such as community-based distribution systems and commercial retail sales outlets need to be developed and widely expanded. Legal and administrative obstacles to free access to contraception should be removed wherever possible, consistent with the protection of user safety.
- The quality of services should be improved, particularly the provision of a continuum of

care from pre-acceptance counselling to post-acceptance follow-up services. Family planning should, where appropriate, include infertility services.

- Special emphasis should be placed on the serious human and health consequences posed by adolescent pregnancy. Family planning information and services should be provided to married and unmarried adolescents through culturally appropriate channels. Young people should participate in the planning and implementation of population, family life, and sex education programmes.

STRENGTHENING MANAGEMENT AND TRAINING

- New management styles and methods should be developed to focus on long-term perspectives in planning, realistic programme priorities and objectives, decentralised modes of operations, and target-setting based on accurate assessment of local needs and sensitivity to the cultural norms of the community.
- Decentralised services will require training and retraining of personnel at all levels, including programme managers, family planning workers, primary health care workers, and traditional practitioners. Continuing in-service training is essential to sustain effectiveness, and there is a need to increase contact between programme staff and local communities. Increased numbers of women should be trained and promoted to ensure their participation in the management of programmes at all levels.
- Data collection and information systems, as management tools, should be kept simple and practical, and should focus on qualitative as well as quantitative aspects of performance. There should be a two-way flow of information between field workers and management. Data reporting requirements by international assistance agencies should be modified to foster, rather than complicate, family planning information systems.

CONTRACEPTIVE TECHNOLOGY AND SUPPLIES

- As wide a range of contraceptive methods as possible should be offered in programmes, including conventional methods and voluntary surgical contraception for both men and women. Breastfeeding should be supported for health reasons and for child spacing. Users and providers should be fully informed about the advantages and potential risks of different methods of contraception.
- Access to safe, modern abortion techniques should be offered to all segments of the population wherever local laws, attitudes, and beliefs permit, since currently available contraceptive methods fall short of providing complete protection. In countries where abortion is not legalised, programmes should provide medical services and care for the many women who suffer from the consequences of badly performed illegal abortions. In these countries, programmes urgently need to conduct further research to document the extent of such health problems. It is also essential that these women be offered effective contraceptive advice to prevent repeat abortions.
- Adequate supplies of contraceptives should be ensured in all programmes. A review of the volume of contraceptive commodities required is necessary to prepare for rapidly expanding needs in the 1980's. International agencies and country programmes should prepare, over the next twelve months, a joint plan of action to ensure needed contraceptive supplies for the 1980's.
- Where cost-effective, local capacities for contraceptive manufacture should be developed, and these efforts should be supported by international assistance. An orderly transition from donor dependency to national self-reliance is essential.
- Governments should strengthen their capacities to select, procure, and deliver contraceptive technologies. Improvements are needed in technical planning and decision-making, as well as in capacities to conduct field research on the safety and effectiveness of methods. New technologies should be carefully introduced by pilot testing and

adaptation to ensure their appropriateness and the ability of programmes to deliver them.

COMMUNICATION AND EDUCATION

- Family planning programmes and international assistance agencies should devote more intensive efforts to communication activities designed to inform, educate, and change attitudes of political leaders and policy-makers at national and international levels. These activities should also be directed to leaders in all fields of development to increase their awareness of family planning and its relation to broader development efforts.
- The coverage and effectiveness of communication activities designed to inform and educate people about family planning should be enhanced. These activities must be sensitive and responsive to the concerns, values, and attitudes of local communities and individuals. Much more communication effort should be invested in family health, family life, and sex education for both adults and young people.

RESEARCH AND EVALUATION

- New qualitative evaluation methods, in addition to quantitative techniques, should be designed to examine social and behavioural change, user satisfaction, staff performance, continuation of contraceptive use, mechanisms of community participation, and the quality of care provided to users.
- Applied research into the health and sociological aspects of family planning should be promoted within established priorities determined by local needs. Research undertakings should strengthen indigenous human and institutional resources, and their results should be more effectively applied and disseminated. Priority areas of research include development of new contraceptive methods, improved ways of using existing methods, acceptability and long-term safety of methods, and programme management and operation constraints.

INCENTIVES AND DISINCENTIVES

- The use of incentives and disincentives involves complex ethical, social, and political issues. These preclude international generalisations and must reflect specific country and cultural situations, reconciling individual freedom of choice and societal needs. The introduction of incentive schemes therefore requires caution and should be accompanied by full availability of family planning information, education, and services.
- Efforts should be made to study the effectiveness of incentives in family planning through carefully designed pilot studies and continuing evaluation. In the design of such incentive systems, emphasis should be given to those schemes which contribute to community improvement, peer recognition, and social rewards.
- Cash incentives to providers and clients for the acceptance of a particular method should be restricted because they tend to distort the user's perspective and may lead to abuse.

Jakarta Statement 30 April 1981

The following statement was approved by the participants and issued at the final plenary session of the International Conference on Family Planning in the 1980's.

During the last ten years a widespread popular demand for family planning information and services has been documented and many family planning programmes have been successfully implemented. One hundred and eighteen governments now support the provision of family planning information and services. However, on the average, less than 50 cents per capita per year is currently spent on family planning and population programmes in developing countries, and the demand for services far outstrips available funds.

Family planning is an essential component of any broad-based development strategy that seeks to improve the quality of life for both individuals and communities. The challenge of the 1980's is to secure the political commitment, financial and human resources to meet the family planning needs of 900 million couples of child-bearing age. The number of these couples in developing countries is projected to double by the year 2000. This challenge was dramatically stated by President Suharto in his opening address to the Conference when he declared, "Successful implementation of family planning programmes will be a key to the survival of the world in the future."

We believe that if the following steps are taken the lives of millions of mothers and children will be saved and the living conditions of individuals in a stabilised world population will be enhanced in the twenty-first century. Eighty million people are added to the global population each year and this annual growth is likely to reach 100 million by the end of the century. We believe that most serious changes may take place in the world environment and the fabric of society if our recommendations are not heeded.

The actions outlined below are of profound practical and moral importance for all mankind and deserve support by political leaders, religious groups, health professionals, development planners and all levels of society throughout the world:

- 1 Family planning is a basic human right.
Governments should be encouraged to translate

this right into realistic policies and programmes which meet the needs of their people.

- 2 A wide range of fertility regulating methods should be made available to men and women, with information on their advantages and disadvantages. These should include reversible methods, and, where legally accepted, voluntary male and female sterilisation. Since most currently available contraceptive methods fall short of providing complete protection against unwanted pregnancy, access to safe, modern abortion techniques should also be offered wherever laws permit. Where abortion is not legal, adequate medical care and contraceptive services should be available to those suffering from the consequences of badly performed abortions.
- 3 Family planning services are most effective when they are initiated, managed, evaluated and controlled by people of the community and when they are sensitive to the values, needs and problems of people. Mobilising community resources and generating local leadership will increase programme orientation towards people and self-reliance, therefore community participation in the planning and provision of family planning services must be ensured.
- 4 Family planning is an essential and integral part of economic and social development. Depending on local conditions, family planning can be linked with health, education, rural development, women and youth programmes. It may also be the lead component of a primary health care programme. Population education must be integrated into formal and non-formal educational systems to prepare future generations.
- 5 The non-governmental sector should be fully used to stimulate and complement government family planning programmes.
- 6 Women and men should be equal partners in social development. Programmes to encourage greater participation of women in community and national life will not only benefit women but also encourage smaller families. Family planning programmes should set an example by

emphasising programme and policy responsibilities for women. The responsibilities of fatherhood should be emphasised for men.

- 7 Adequate supplies of contraceptives must be ensured for all people. Because of rapidly expanding needs in the 1980's, planning and action to ensure continued availability of these commodities is necessary, and appropriate centres of manufacture should be established in the developing world.
- 8 Improved means of fertility regulation are urgently needed. The safety, acceptability and effectiveness of methods must be enhanced. Support for research to improve existing methods and to develop and test new technologies must be substantially increased.
- 9 There is an urgent need to increase current overall expenditure in developing countries from an estimated current \$1.5 billion to approximately \$3 billion annually in order to meet population and family planning programme needs. Countries providing development assistance should increase their support of population programmes from the current 2.1 per cent of development assistance outlays to at least 5 per cent. At the same time, the developing countries should substantially increase the proportion of their public expenditures which are allocated for family planning programmes.

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Keynote Speech

This speech was given by Dr. Fred T. Sai, Chairman of the Conference, at the opening session at the Hotel Indonesia, Jakarta.

Family Planning in the 1980's

It is an honour and indeed a great pleasure to be in this lovely country of Indonesia and to have the privilege of chairing this meeting and making the first statement on the substance of the Conference. I would like, on behalf of us all, and on my own behalf, to thank the Indonesian Government and the Indonesian Planned Parenthood Association for all the efforts they have made to make this Conference come about.

Collaboration between inter-governmental and non-governmental organisations as equal partners in planning and organising this Conference is a pointer to the future. An effective partnership between governmental and non-governmental sectors will be a key to progress in development efforts during this decade.

There has been no specific international conference devoted wholly to the subject of family planning since 1965. Family planning was indeed discussed at the World Population Conference in 1974, at the World Conference of the International Women's Year in Mexico in 1975, and at the World Conference of the UN Decade of Women in Copenhagen in 1980. At the World Population Conference, there was much debate on the inter-relationships between population and development and questions were raised as to which should come first and which should follow. To some of us family planners, it even seemed that the direct link between population and development and the direct contribution of family planning to development, were not being recognised. Fortunately, when the smoke cleared, a strong consensus emerged that family planning is indeed an integral part of the socio-economic development process.

I have to say at this point, however, that we should not be lulled into silence by the lack of serious opposition to family planning at the international level. We should not think for a moment that we really need not be aggressive anymore or very open about what we are trying to do. There is no course which is likely to lose its way as readily as a course that gets itself lulled into thinking that once the rhetoric is going in the right direction, the action has followed or will automatically follow. This has not been the usual experience. There are indicators right now that opposition remains in many parts; in some situations, it will become even more active. We should speak out openly

in the face of whatever opposition there is. We know that despite the rhetoric, there are whole regions, and I may mention in particular my own, Africa, where family planning still is not making much progress and large numbers of couples are going to bed without any knowledge or means to regulate their own fertility. The need for aggressive, concerted action is as great as ever.

It is also necessary, at this stage, to look ahead into the future environment - the world environment - in which family planning will belong, during and beyond the 80's. We should look at the socio-economic, political, cultural and other relevant factors in this environment.

There are many major global issues which exert a strong influence on both the climate of opinion and on financial and other resources needed for family planning as well as for other development efforts. The North-South relationships which at present are rather soured, as demonstrated by lack of progress in trade negotiations, commodity price stabilisation efforts, and so on, do not provide a healthy environment in which we can advocate family planning without controversy. The rather lukewarm reception to the Brandt Commission's report, a report which seeks to express the oneness of the world today, the interdependence of North and South, is another disturbing evidence of a world which is becoming less selfless rather than more so.

Many governments of the more industrialised countries seem to be scaling down their assistance to developing nations at a time when it is becoming more needed. Aid is being looked upon more and more as a political weapon for rewarding 'little boys that behave well' than as a genuine effort to help create self-sustaining development in all parts of the world. This climate creates a tendency to divide the world in two camps and foster distrust between North and South. This distrust has reflected itself in statements alleging that family planning is an imperialist tool to keep down numbers of populations in developing countries, so that those in the North can enjoy the fruits of the world without too much competition. Our statements that this is not so may sound rather hollow unless the climate of aid and the climate of interdependence change.

The energy crisis exploded on an unsuspecting world in 1973/74 and its effects have been disproportionately severe on developing countries. Those without oil are now against the wall - their development aspirations are thwarted. The richer devel-

oped countries are not as badly affected though they make extreme postures and use the problem as a reason for decreasing development assistance and making difficult aid negotiations. In such a situation, advocacy of family planning would come up against the same argument of keeping resources away from the mouths of developing nations.

Food is now becoming a major and critical issue. No one seriously doubts the global capacity to produce enough food for a hungry world, but the means and the ability to handle the food problem as a global issue is being questioned. Some of us do not feel that with mankind's present political structures and political approaches it is possible to handle the food problem on anything but a national basis, and this is a shame. Many developing countries are not producing enough food for their people. If I may refer you again to my own continent, Africa, it has been estimated that the average African eats 10% less food today than he did in 1970. Despite the sharp increases in grain imports over the past several years, the situation is getting worse. Many countries in Africa which in the past were self-sufficient in food are now net importers of food. Africa's negative trade balance in grain has trebled since 1960 according to one study by the US Department of Agriculture. When one recalls that the food situation in the 1960's and 70's was not considered exactly adequate, then one sees the threat that Africa faces and poses.

It is not only in Africa that we hear of famine and threats of famine, devastations by war, increasing refugee numbers which add up to worsen the problem of food and nutrition. If this problem is not tackled with vigour, the detractors of family planning can, with some justification, claim that family planning is being resorted to as a Malthusian soft option. Mention of the intellectually and morally bankrupt triage theory does not help our cause either. We know we have valid humanitarian reasons, but we must be aware and be involved in the overall efforts to address these major problems to ensure social justice within nations and among nations. Family planning cannot be in a pigeon-hole by itself. The advocacy role for all concerned citizens for important causes must be a major task for family planning organisations and family planning generally. It is only then that specific family planning efforts can have the moral and ethical status within any community and internationally.

RATIONALES FOR FAMILY PLANNING

In the environment mentioned and in the local situation we should constantly analyse our basic reasons for family planning and the objectives and goals of programmes. The first and foremost rationale for family planning should remain the human rights rationale. The basic right of individuals and couples to decide "freely and responsibly the number and spacing of their children" was first recognised in the Proclamation of Teheran, adopted by the International Conference on Human Rights in 1968. This right, and the right to have the information, education and the means to exercise it, constitute one of the main principles of the 1974 World Population Plan of Action (WPPA) and have been confirmed in the resolutions of the 1975 Women's Conference. The Teheran Proclamation was ratified by some countries and not by others. The WPPA and the Mexico resolutions, however, were accepted by practically the whole world, firmly establishing family planning as a basic human right.

Within this right is the issue of status and emancipation of women. It is a woman's right to choose when to have a baby or even whether to have a baby and how many babies to have. Without the ability to plan her fertility and to determine when and how many children she should have, it is not likely that a woman would be able to plan and control any other activity well enough and take active steps to improve her own living conditions and those of her children.

It is also the right of children to be planned for and born at a time when they will not lack the emotional and material sustenance that is their due. It is the right of an infant, for example, to have adequate breastfeeding and individual love, both of which are lost if that infant is deprived of its mother's breast and its mother's attention by too early a subsequent pregnancy. The full emotional attachment of the mother to a child is only now being recognised as a major input into emotional and psychological development.

Let me state right now that there can be no decision without a knowledge of options. Despite the fact that the world has accepted family planning as a human right, unless individuals and couples are given education as to the options available to them and provided with adequate services, they cannot make a choice on whether and how to plan their families. In making a choice, however, they have a

clear responsibility towards their immediate community and their nation. Societies, too, have to plan their own sizes in accordance with national needs. In some instances, there might appear to be a conflict between individual rights and societal responsibilities. A reconciliation of these two is among the responsibilities of national family planning programmes.

The health rationale for family planning has been extensively discussed, but a few points are worth reiterating. It is now established that all the indicators of health such as infant mortality rate, abortion rate, low birth weight, poor maternal performance, maternal malnutrition, are very much worse when child-bearing starts early, continues late or is poorly spaced. Starting child-bearing at an age earlier than 20 carries added risks to the life and health of both the mother and the children. The most opportune age to start child-bearing is in the early 20's and the best age to stop is after 35, with a spacing of three to four years per child. Those who withhold family planning education and services from individuals and couples must know that they are denying human beings the benefit of a powerful health measure.

To me, these two rationales are probably the most important and the most universally applicable rationales for family planning programmes. However, there are some other reasons for which family planning is pursued. Among them, demographic and economic concerns may be specifically mentioned. There are both macro-economic factors at national and regional levels and micro-economic aspects at the family level which need to be taken into account when considering rationales for family planning. These are very important issues and require serious discussion at national and international levels. Some of these macro and micro aspects play back to the human rights and health rationales which I consider the most important.

I have already mentioned the question of food production. The distribution of food among the population also requires careful planning. Development of health and education services and other development efforts are all situations which relate directly not only to the total number of individuals but the rates at which those numbers are being added to by births. Without education, employment, health services and food adequate in quantity and quality, health cannot be maintained. An overall population policy which helps a country or region to plan and solve its problems and to ensure freedom from want

and general progressive development for its people is an objective to strive for. Within such a policy, family planning has an important role.

The Background Document before you examines other rationales that have been put forward by some - such as family planning as an input into national security, peace and stability. It is not my intention to dwell on these at this stage.

THE CHALLENGES AND OPPORTUNITIES

Some major issues confronting family planning programmes in the 1980's are discussed in the Background Document and the key challenges are identified. All these issues and challenges are very important and I am sure due attention will be given to them in our deliberations in the next few days. I would like to concentrate on some of these issues:

The Background Document states that "the first and most immediate challenge for the 1980's is to improve the quality and to strengthen the operational capacities of public family planning programmes so they can provide their services more effectively and efficiently," and that "the second major challenge for the 1980's is to extend the opportunity and benefits of contraception to the hundreds of millions of people who currently do not practise family planning because of lack of access to services or lack of interest in using them."

These two challenges can really be rolled into one and their cardinal point is how to make family planning information advice and services available and accessible geographically, socially and economically to all the millions who need them wherever they are. Among groups having most difficulty with family planning and contraception are the young and the adolescent.

This is both a demographic and a human problem. The population of developing countries is growing at a very rapid rate although they have high infant and young child mortality rates too. The proportion of population under the age of 15 ranges between 40 and 50 percent. This means, in terms of fertility, that the mothers of tomorrow have already been born and that their numbers are very large. It means that the population is youthful and if nothing is done to change its fertility aspirations and behaviour now, population growth will remain a serious problem well

into the next generation. But this demographic problem has to be looked at in human terms too. A key challenge of the 80's will be child-bearing among adolescent and young women. This is not only a developed country problem, although from the press and from publications one may be tempted to think so.

In many cultures, marriages traditionally have been arranged long before young women reach adulthood and, in some, as soon as they reach biological maturity they are given into marriage. With today's health and nutritional improvements, there are biological changes taking place in human development. Women are arriving at puberty very much earlier than in the past, and yet there is a socio-cultural change taking place which requires that they remain in educational and training institutions for longer periods. There is thus a biological and social gap which leaves biological adults as social youngsters. It is this gap that leads to relatively early child-birth which is now being recognised as a major problem in many countries.

Of course, in some developing countries, young child-bearing - that is, starting child-bearing under 18 or so - was always the norm, but it took place in recognised marital situations and therefore there was not great social upset about it; the health toll was and is high. Now, however, we family planners should not accept a situation which we know to be biologically and socially unsatisfactory. For health, child-bearing should be postponed. The social demands are such that those who are going to school need to be protected through abstinence if at all possible. But this is not likely to be an effective or universal solution. Therefore, there is an urgent need to look at the adolescent pregnancy issue and the provision of information for adolescents as a major family planning requirement.

This issue creates problems of morality and ethics for many and this should be respected and confronted in a realistic way. Changes in morality are of concern to us all but should not be used as an excuse for preventing family planning. It has not been satisfactorily proven, in any situation that I know of, that availability of contraceptives leads to promiscuity in youngsters. What has been proven is that non-availability leads to early and unplanned pregnancies and abortions in very appalling circumstances. In this respect, the role of family planning and family planners should be to inform opinion leaders about the severity of the prob-

lem; to advocate reforms that are needed to make it possible for this problem to be tackled both in an education and a service sense; to create youth programmes including access to contraceptives, where necessary, and the participation of young people in the planning and execution of their own programmes.

Another issue of very grave concern in family planning is the issue of male responsibility. In many developing countries, decisions about fertility are taken by the male or a relation of the male and yet most family planning efforts have in the past been geared to the female. This is natural because, biologically, the load of fertility has been on the female. The male methods of contraception are woefully inefficient and cumbersome. Nevertheless, it is necessary to educate males about family planning and its importance to their lives and the lives of their children. It is necessary to make men understand how they can help the women-folk and support them in using family planning methods, and how they can take a greater responsibility in contraceptive practice. Where possible, the use of the 'condom' which, at present, does not seem to many men too satisfactory, can and should be encouraged very much more than it is now. The Japanese experience has proved how very efficiently and effectively the condom can be used. Meanwhile, however, research is needed into male contraceptive methods that will play a major role in contraceptive technology. But the signs for a quick break-through are not bright.

CONTRACEPTIVE TECHNOLOGY

At the present time it is unlikely that there will be any major break-through in the technologies that are available to us now. As the Background Document in front of you mentions, there are likely to be slight or significant modifications which will improve efficiency and ease of use of some methods now available, but I do not think that it would be a responsible position for anyone to feel that family planning will improve and move forward rapidly only if better technology is available. The same technologies that are available today, imperfect though they are, have proved effective and efficient in diverse circumstances. What this means is that with appropriate delivery systems, these technologies can work better than they do now. Many people have been

attacking current technologies largely because they carry side effects and risks. Some even maintain that some of these side effects and risks are unacceptable. But if contraceptive technology is used in a way which ensures proper counselling, proper follow-up and proper referral, the seriousness of at least some of these side effects will be minimised considerably.

There is a tendency on the part of some family planning programme managers to choose one or two of the technologies available and stick to them. Sometimes, government policies limit the choice of contraceptive methods. By and large, family planners must be completely aware of all the technologies that are available and the circumstances within which they work best. They should give concrete and comprehensive advice to their clientele to enable them to have the opportunity to make a free, informed and responsible choice. These technologies must include the pill, the injectables, the mini-pill, condoms and sterilisation and, where appropriate, even abortion.

Meanwhile, research efforts must be strengthened for a more effective post coital and end-of-month pill for those who only have occasional sex, particularly youngsters, and for male contraceptives.

FAMILY PLANNING DELIVERY SYSTEMS

The contraceptives that have been mentioned should be handled in a way that makes them geographically and socially accessible to the clientele. This means that the users themselves must be involved at all stages of the planning of the programmes and in the delivery of the services. It is in this respect that the question of integration of family planning into other development efforts becomes a major issue.

Family planning is an integral part of socio-economic development, but the statement "take care of development and family planning will take care of itself" is an oversimplification. It is possible to undertake large-scale development efforts and yet have family planning practice lagging very far behind in time. There are also examples that an active family planning programme can help and be a lead agent to other economic and social development in communities. It is necessary, therefore, not

only to expect family planning programmes and projects to carry other programmes with them, but also to see how it would be possible to integrate family planning activities, be they education or services, in other development activities.

Any programme or project that is aimed at development, especially rural development, agricultural development, should be seen as a possible vehicle for family planning education and service programmes. In these family planning delivery systems, one major area of concern would be the role of the community as a whole in the programme. This is now accepted as a major aspect of any kind of development effort. The community should not be looked upon as a passive receiver of services. Things must be done by the community and with the community. The community should be the chief planner and the implementer. External leaders can give appropriate stimulation and they can help with evaluation. What this Conference needs to discuss is how to bring about this participation. What are the ingredients? How can charismatic leaders be brought into family planning? What is the place for grassroots organisations? What can people's organisations do for self-development? What is the role of the government? These are all important questions and it is my hope that examples will be brought to the floor and analysed so that in the exchange of experience we will learn valuable lessons in how to get the community involved. It is only by involving the community as a whole in this effort that we will be able to maintain a proper 'user perspective' on our activities. In the past, we have tried to give family planning to people without considering their circumstances and how they themselves view their family planning needs. Yet, the way they view their needs can be capitalised upon to help organise with them their further education and services. It is time that the user became a very much more active participant in the whole family planning field than he/she is now.

LEGAL REFORMS

Before ending, let me raise two points which will continue as burning issues in the 80's. These are legal issues related to abortion and sterilisation. Abortions have been with mankind from the beginning

of time and they will continue to be a problem. Family planners should understand the ethical, moral and other implications of abortion and should take their own counsel as to where they stand and why. This is a problem which should not be looked at as something which will go away, because it will not. It is encountered in all cultures and in all communities.

As a result of the tremendous advancements in abortion technology, where laws are liberal, women in need are able to have their abortions safely. The figures from all countries that have liberalised their abortion laws prove this point. Where the laws are restrictive, they do not prevent abortions from taking place. This must be understood for everybody. What these restrictions do achieve is to make it possible for the well-to-do and the better educated to have their abortions in safe and good conditions even though they pay a high price for it. Their sisters who are poor or less educated, when desperate, are driven to back-street abortionists where they have their abortions in unsanitary conditions and pay dearly from the little money they have and with their health and sometimes even with their lives. If one looks at the human cost of illegal abortions, one cannot but pray that some day all countries will understand this and take the proper steps to see to it that modern technology is not being denied to a section of their population. A more concerted effort is needed at the national level to understand the human problem of abortion, its moral, ethical and social dimensions as well as its health implications, and to bring these forward in discussions and debates to ensure a proper understanding and a proper approach.

There are communities also where there are laws against sterilisation. At the present time, sterilisation would appear to be the best method for both men and women who have completed their families. It is a relatively simple operation in the male and perhaps more countries should encourage and pass laws providing for male sterilisation as a very much more serious option for terminating child-bearing. Male and female sterilisation must not be prevented by laws, and where such laws exist, it is the responsibility of family planners to try and see that they are repealed or changed.

There are a large number of other laws that need to be enacted or repealed. These include the laws which influence the age of marriage, laws which influence the distribution and sale of contraceptives and laws which influence the delivery systems

within which family planning services and education generally are to be provided. What we need from this Conference is a re-dedication of all of us here to the goal of ensuring the availability of family planning education and services to all within the next 20 years at the very most. We must see to it that all the necessary steps to achieve this goal are taken at national and international levels. For this, we all need a strong political commitment as well as the commitment of financial and other resources, which brings me to my final points.

POLICIES AND RESOURCES

At the beginning of my speech, I referred to a number of political issues that affect the acceptance of family planning. Throughout the world, there is a need to bring about, strengthen and constantly reinforce political commitment to family planning. When I talk about political commitment, I do not only mean commitment by people at the top, which is an essential element in the success of family planning programmes as the experience in this country has clearly shown, but a commitment by those who are in decision-making positions at regional, local and community levels.

In the face of all the challenges and opportunities I have talked about, it is a depressing thought that resources devoted to family planning are not rising as rapidly as the growing need. This Conference should draw attention to this serious problem and call for an increase in national and international resources which is commensurate with the efforts that are required. At the national level, most countries which now have family planning policies and programmes do not devote adequate resources to their efforts. In many, the resources specifically allocated to family planning are pitifully small while the challenge is big. Therefore, national resources in terms of money, in terms of facilities and in terms of human resources for administration, research and implementation, all need to be mobilised and increased if the goals we have set ourselves are to be achieved in a reasonable time.

However, it is not likely that national self-sufficiency in the provision of family planning education and services will be reached in the next few years. Therefore, the continuing and even

increasing support of the international community will be needed during the decade. A most serious gap at the present time is in the resource base for contraceptive research and development. There is an urgent need for rapidly enlarging this base.

CONCLUSION

I hope, Ladies and Gentlemen, that you will take these as well as all the other points made in the Background Document into serious consideration. Don't be afraid to face the challenge. The time for putting on kid gloves and saying that the subject is too sensitive is over. Although it has its opponents, family planning is no longer an internationally contentious subject. What is contentious at the present time is how we do it, how we get the resources and how sensitive we are to those who are in need.

Thank you.

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Background Document

This document was written by S. B. Schearer and N. Financioglu, with contributions from S. Perl, G. Brown, B. Baron, M. McEvoy, and S. Isaacs. It was published prior to the Conference and used as the basis for discussion and recommendations.

I. INTRODUCTION

The International Conference on Family Planning in the 1980's has been organised to take stock of the major developments that have occurred in efforts to provide family planning services over the past two decades and to chart a course for the decade ahead.

There has been no international assessment of the progress in family planning efforts since the 1965 Conference on Family Planning in Geneva. Since then, dramatic strides have been taken in the field and major achievements have been made. Most importantly, some 90 million people in the developing world are now practising family planning, largely through efforts of organised governmental, non-governmental and commercial programmes. In some countries, significant fertility declines have occurred, and organised family planning programmes have played a major role in this. Despite these advances, new initiatives are urgently required if family planning services are to effectively reach those in need.

The Conference has been organised to address three principal objectives:

1. To identify key problems and issues relevant to the design and operation of family planning programmes;
2. To propose strategies to improve the availability, accessibility, and acceptability of family planning services in accordance with people's needs and preferences; and
3. To suggest means to strengthen community, national and international commitment to family planning as an essential component of development, supported by the requisite human and financial resources.

This Conference is intended to provide a benchmark assessment of the family planning field and to make substantive contributions to national and international policy formation and programme development in the decade ahead. The Conference will focus primarily on developing country programmes, although many of the issues raised apply to developed country programmes as well. This background document provides a frame of reference for the Conference deliberations and background for recommendations that will be considered.

The document examines the key issues related to the Conference objectives. It reviews the basic

underlying rationales for family planning from the point of view of both the individual and nation, and briefly summarises the current status of national and private family planning efforts in the Third World. The document then turns to the challenges and opportunities that lie ahead, highlighting the new approaches that offer promise of substantial improvement in the extent and quality of family planning services throughout the world. These include the incorporation of the perspective of the user and the effective participation of the community in the design and provision of services, integration of family planning with other development sectors, especially health, and the reconsideration of male and female roles in relation to family planning.

These approaches need to be incorporated into programme design in order to increase acceptability of family planning and to expand the availability of services through a variety of distribution strategies. This in turn requires the development of appropriate management systems, emphasising flexibility and decentralised operational mechanisms. Expansion and reorientation of training and communications, as well as more effective use of existing and future technologies are all necessary to achieve the goal of making family planning available to all those who want it, in ways that are responsive to people's needs.

Two fundamental issues must be resolved if the family planning field is to meet the challenges it faces in the 1980's. The first is an urgent need for increased commitment to family planning at international, national and local levels. The second is the mobilisation of necessary resources at all these levels, with emphasis on increased national and local self-sufficiency, since it seems unlikely that international assistance will increase sufficiently to meet rising levels of demand over the next decade.

II. RATIONALES FOR FAMILY PLANNING

Only a few decades ago, family planning could not be publicly discussed without overstepping the bounds of propriety. As a personal matter, people in most countries knew little about the subject, and even fewer made use of some form of contraception. Only

a handful of different types of contraceptives existed, and only a tiny minority of the world's citizens had access to services and to sources of supply. A dramatic social change in the second half of the 20th century has been the rapid emergence of family planning as a widely accepted idea that has now been adopted in practice by approximately 270 million people throughout the world. Although family planning has often been the subject of controversy during this period, as the world enters the decade of the 1980's the basic rationales for family planning have become clarified and have gained wide acceptance. Taken together these rationales constitute a compelling argument for continued and accelerated action to provide family planning services to all who want them.

PEOPLE'S NEED FOR FAMILY PLANNING

For many people, being able to time births and to have their desired number of children is essential if they are to achieve the quality of life they seek for themselves and their children. People want to control their fertility in order to fulfil their personal and marital aspirations and to ensure the economic and emotional well-being of their families. Despite controversies about the merits of family planning, many people in every society--with or without government support--want access to family planning services. While governments have sometimes not responded to this need, the existence of this evident desire for family planning in every country of the world remains one of the basic foundations for family planning in the 1980's.

THE CONTRIBUTION OF FAMILY PLANNING TO HUMAN RIGHTS

People's wish to have the number of children they feel they can support and care for is so central a rationale for family planning that it has become codified as a basic human right recognised by most nations of the world. The 1968 Teheran Proclamation of Human Rights and the 1974 World Population Plan of Action called upon governments to make it their duty to ensure that their citizens have access to family planning information and services so that they may effectively exercise this right.

For women, this right has a special meaning. The ability to control their fertility enables women

to take advantage of educational, vocational, and employment opportunities, to enter into a more equal partnership with men and to contribute more actively to the economic and social life of the community. When combined with other efforts to improve the status of women, access to family planning information and services helps women play their full role in the development process.

THE HEALTH BENEFITS OF FAMILY PLANNING

Another basic rationale for family planning is the health benefits it confers on both mothers and children. In almost every culture, people recognise and fear the danger to a woman's and her infant's health if she has a large number of pregnancies. There is also a significant risk of mortality and morbidity for both women and their infants when childbirth occurs at very young ages, near the end of their reproductive years, and when births are not adequately spaced. Maternal malnutrition adds to these risks, and is in turn aggravated by repeated pregnancies. These risks to mothers and children are universal, but are particularly acute in countries where health care services are limited and nutritional levels are inadequate. Family planning significantly contributes to improved maternal and child health by enabling women to delay and space childbearing and avoid unwanted pregnancies.

In some countries, another important health benefit is conferred by family planning. This is the dramatic reduction in deaths, hospitalisation and serious illness that the use of contraception brings about where abortion is an illegal practice. In places where family planning is not available and abortion is illegal, large numbers of women turn to backstreet abortion to control their fertility, resulting in high morbidity and mortality.

More than 100 nations throughout the world now officially support family planning, and health is a primary rationale for their adoption of this policy. Recognising these important health benefits, the Declaration of the Alma Ata Conference in 1978 included family planning as one of the basic components of primary health care.

THE CONTRIBUTION OF FAMILY PLANNING TO SOCIAL AND ECONOMIC DEVELOPMENT

During the 1960's, it became widely recognised that very high rates of population growth in many developing countries were placing great economic and social constraints on national development efforts. Rapid rates of population increase and high dependency ratios due to a very young age structure continue to put added burdens on already inadequate food production, housing, education and health facilities, and job opportunities. Many of the advances in these sectors have been consumed by rapid population growth, thus limiting overall improvement in levels of income, nutrition, education, employment or health. Many governments have expressed concern over the dramatically increased number of unemployed people, the rapid and uncontrolled growth of cities, the migration of large numbers of workers both within and between countries, and the continuous subdivision of agricultural land. For these reasons, many governments and international development organisations view rapid population growth as a complicating factor in improving social and economic well-being for their people. Family planning programmes can contribute significantly to these development efforts by accelerating reductions in rates of fertility, thereby slowing population growth.

* * *

Each of these rationales is an important justification for family planning at the individual, national, or international levels at different stages in the evolution of family planning policies and the initiation of large-scale programmes. The relative weight given to individual-level as opposed to national-level rationales can have important implications for programme policy and implementation.

Two additional rationales have been discussed and debated as further justifications for the need to reduce population growth rates through family planning efforts. While these viewpoints have not received universal acceptance and, indeed, continue to be controversial, they nevertheless are considered important by some governments and institutions.

The first entails the links between population growth and the environment. Degradation of the environment, long a serious problem in developed

industrial development and consumption in developed countries have been the major source of ecological instability in the world to date. But there are serious problems of deforestation, overgrazing and soil erosion in many developing countries that are partly the result of growing population pressures. More generally, the earth has a limited capacity to absorb the increasing exploitation of its natural resources and the burdens of a constantly growing world population. Many believe that reduction in population growth rates through family planning, while not providing a solution by itself, may make solutions to these environmental problems easier to find and implement. However, there are differences of opinion over the degree to which rapid population growth contributes to these national and global problems.

A further controversial rationale for family planning is based on concerns that rapid population growth and urbanisation may contribute to political instability within developing countries; that growing levels of unemployment in developing countries will lead to increased pressures of international migration; and that rapid population growth, combined with rising incomes, will increase international competition for scarce global resources. Family planning is therefore seen as contributing to domestic and international stability by reducing population growth rates. This rationale has provoked controversy because many believe other factors to be more important in promoting political and social stability. Others give more weight to the need to enhance equity and human development than to concerns about potential instability. Debate about the validity of this rationale is likely to continue throughout the 1980's.

III. CURRENT STATUS OF FAMILY PLANNING

This section examines the current state of family planning, with particular emphasis on developing world countries. It reviews national policies and laws, the provision and financing of family planning services, and the extent of contraceptive practice. The contents of this section, which are presented in expanded form in the Annex, establish a framework for considering the issues and options discussed in

Section IV, "Challenges and Opportunities for the 1980's."

NATIONAL LAWS AND POLICIES

At present, almost all of the developed world and a majority of developing countries support family planning. Of 158 countries responding to the United Nations Fourth Inquiry Among Governments on Population and Development, 118 had adopted laws or policies favourable towards family planning or supported family planning through public or private sector programmes. The justification for policies supportive of family planning frequently varies by region.

- In the 1950's and 1960's, many Asian countries recognised the deleterious effect of rapid population growth and adopted official policies to reduce such growth. To date, 18 Asian countries, accounting for 94% of the population of the region, have adopted policies to reduce population growth rates. In addition, many governments of the region have established national family planning programmes, have taken steps to assure wider availability of contraception and have revised their laws in order to reward small families.
- In 1965, the maternal and child health programmes of only five Latin American and Caribbean countries offered contraceptives. Currently all but three countries in this region offer family planning as part of the government's health services, justified principally on the grounds of promoting maternal and child health. Seven countries have established targets for reducing population growth rates as part of their development plans.
- In sub-Saharan Africa, mortality, especially infant mortality, is the highest of any region of the world, and in most countries there is little concern over population pressures or availability of land. For these reasons fifteen countries have adopted policies which either limit access to modern means of contraception or are not supportive of it. Nine countries have policies to reduce population growth, while the remainder

support family planning to improve maternal and child health.

- Since the mid 1960's, a number of Middle Eastern and North African countries, including Egypt, Morocco, and Tunisia, have supported family planning to facilitate development. A number of other governments of this region promote family planning on the grounds of its benefits for maternal and child health, while most oil-producing states have not officially supported family planning.

Worldwide, the past decade has been marked by fewer restrictions on the distribution of contraceptives, particularly the distribution of oral contraceptives by non-physicians, and by greater access to voluntary sterilisation through changes in the relevant laws or their interpretation. In addition, the abortion laws of many countries have been liberalised. However, the laws of many countries, particularly in Africa and Latin America, restrict access to contraceptive services, voluntary sterilisation and abortion.

PROVISION OF FAMILY PLANNING SERVICES

National policies favourable towards family planning are not necessarily reflected in strong programme action or budget support. But despite the gaps between policy enunciation and programme action, many developing countries have achieved dramatic success with their family planning programmes over the past decade. Family planning services can be provided by governments, non-governmental organisations, and the private commercial sector.

- Government family planning programmes usually come under the aegis of the Ministry of Health, although in some countries services may also be provided by a social security agency or other ministries. Most services are provided in hospitals and clinics, but fail to reach people living in rural areas and urban slums beyond the reach of the governmental health system. Some governments--such as those of Bangladesh, China, Egypt, Indonesia, Mexico and Thailand--have instituted large-scale programmes to provide services to inhabitants of rural and urban slum areas.

- Historically, the national associations affiliated with the International Planned Parenthood Federation have been the pioneers of family planning. Currently, 95 such associations exist, their roles varying from being the sole provider of information and services in some countries to complementing and supporting government programmes in others. Many other non-governmental organisations such as agricultural cooperatives, labour unions, women's clubs, and religious organisations have also played active, if less widely recognised, roles in the delivery of family planning.
- Although accurate figures are not available for most countries, commercial retail sales play a significant role in supplying contraceptives. The range is considerable, however. In the Dominican Republic and El Salvador, the private-sector accounts for more than two-thirds of the supply of contraceptives; in Korea, Costa Rica, Mexico, Taiwan and Malaysia, it accounts for about 50%; and in Singapore, about 20%.

In recent years, as the concepts of community health and primary health care have gained acceptance and as shortcomings in clinic-based family planning programmes have become manifest, there has been an increasing effort to extend family planning into smaller rural communities and urban slums. These new approaches, utilised by governmental and non-governmental groups alike, have included family planning integrated with primary health care and other development programmes, contraceptive distribution by trained auxiliary personnel such as midwives, auxiliary nurses and community workers, and greater use of commercial channels.

- Integration of Family Planning with Primary Health Care and Development Programmes. An increasingly important way of providing family planning services is to integrate them with primary health care and other development activities, especially at the village level. This accords with the Declaration of Alma Ata which emphasised the importance of primary health care--including family planning--and is in keeping with the priorities of many national governments. In many cases, auxiliaries or other members of the community

can be trained to deliver primary health care including family planning; in other cases, health care and other development activities can be added to already successful village-based family planning programmes.

- Community-based Distribution (CBD). Utilising trained health personnel or community workers to provide family planning services, CBD projects have been established in nearly 40 countries. Although most projects serve small populations, large-scale CBD projects exist in Bangladesh, Brazil, Colombia, Egypt, Indonesia, Korea, Mexico, the Philippines, and Thailand. Although in virtually all CBD projects members of the community provide family planning services, considerable diversity exists among programmes regarding the people selected as distributors, the training they receive, the types of services they provide, and the way in which they are supervised and supplied. Analyses based on limited evidence have indicated that CBD programmes have been an effective way--and in some instances the only way--of serving hard-to-reach rural populations and urban slum residents.
- Commercial Retail Sales. While pharmacies and other retail outlets have sold contraceptives for a long time and are now considered a major source of contraceptive supplies in many countries, it is only recently that attention has been directed to developing programmes that use the market system as a channel for contraceptive distribution, often at subsidised prices. Currently, projects in more than 30 countries, supported and financed by both governments and non-governmental organisations, utilise retail outlets such as pharmacies and small retail shops to distribute contraceptives. The experience to date of these programmes indicates that they have succeeded in improving contraceptive availability and increasing sales of contraceptive products.

FAMILY PLANNING TECHNOLOGY

The last two decades have seen a technological revolution in the methods available for controlling

fertility. Most of the methods widely used today were introduced since 1960, many of them during the last decade. Seventeen major categories of birth control technology currently exist. Included among these are nearly 100 distinct forms of contraceptive drugs and devices marketed under more than 600 brand names. The principal categories are:

Behavioural Methods

- Withdrawal
- Abstinence (nonsystematised, calendar rhythm, temperature rhythm, symptothermal rhythm)
- Coitus reservatus
- Prolonged breastfeeding
- Postcoital douching

Drugs and Devices

- Oral contraceptives (standard dosage, low-dose regimens)
- Progestin-only minipill oral contraceptives
- Injectable contraceptives (monthly, 3-monthly)
- Postcoital pills
- Intrauterine devices (inert, drug-releasing)
- Vaginal spermicides (foams, creams, jellies, tablets, suppositories)
- Vaginal barrier devices (diaphragms, cervical caps)
- Condoms

Sterilisation

- Vasectomy
- Female sterilisation (via laparotomy, mini-laparotomy, laparoscopy, culdoscopy)

Abortion

- Early abortion (menstrual regulation, first trimester)
- Late abortion

A large proportion of the contraceptive drugs and devices used in family planning programmes in developing countries are manufactured by commercial enterprises in Europe, North America and Japan and supplied to these programmes by development assistance agencies. In recent years, however, this proportion has begun to decline as local manufacture, either by private companies or government-sponsored enterprises, has become more widespread.

None of the currently available methods are free of drawbacks. Both short-term side effects and long-term hazards to health are associated with many of the devices and drugs, while the barrier methods

and behavioural techniques are difficult to use and often only partially effective. Sterilisation and abortion both entail surgical risks and, especially in the case of abortion, are the subject of considerable controversy because of ethical and religious objection to their use.

FAMILY PLANNING PRACTICE

It is estimated that throughout the world today, approximately 270 million people utilise some form of contraception, about two-thirds of them in developed countries and one-third in developing nations. About one-third have been sterilised, roughly 20% use the pill, 15% the IUD, and 10% the condom. The remaining 20% use contraceptive injections, the diaphragm, various types of spermicides, different forms of periodic abstinence, or traditional techniques such as postcoital douching, withdrawal, and reliance on the antifertility action of breastfeeding. In addition, an estimated 30-35 million induced abortions are performed annually throughout the world.

Considerable regional and national variations underlie this global picture. Among developing countries, the contraceptive prevalence rate is less than 20%. Low contraceptive use levels are found in most African and Middle Eastern countries, and in Afghanistan, Bangladesh, Bolivia, Burma, Ecuador, Haiti, Pakistan, and Paraguay. At the other end of the spectrum are at least seven developing countries (Costa Rica, Cuba, Hong Kong, Mauritius, Panama, Singapore and Taiwan) where contraceptive prevalence is 50% or more. Most significantly, there is a trend observable in almost all Latin American and Asian countries and some Middle Eastern nations towards higher contraceptive prevalence.

The most striking development in recent years is the rise in popularity of voluntary sterilisation which has become a major method of fertility control in such diverse countries as El Salvador, the Dominican Republic, Korea, Fiji, India, Sri Lanka and China.

The extent to which fertility declines can be attributed to family planning or to socioeconomic development has been the subject of debate. Cases exist where fertility has declined rapidly in the presence of family planning programmes and the absence of significant development; other cases can be found where fertility has declined in the absence of family planning programmes. However, a consensus

is emerging that both family planning and development contribute to fertility decline and that the two have a synergistic effect. At the very least, a strong empirical correlation has been shown to exist between levels of contraceptive use and fertility. Data from 32 countries show that, on the average, a 2.4 percentage point increase in contraceptive practice in a country is correlated with a 1-point decline in the country's crude birth rate. In developed countries where contraception is practised by approximately 70% of all reproductive-age couples (which represents virtually all couples in need of contraception), birth rates are low, averaging 16 per 1,000. In the developing world where less than 20% of reproductive-age couples use contraceptives, the average birth rate is about 34 per 1,000.

Although fertility levels of developing countries are more than double those of the developed countries, fertility rates throughout much of the developing world have been declining, in some cases sharply. Chile, China, Colombia, Costa Rica, Cuba, the Dominican Republic, Egypt, India, Indonesia, Malaysia, the Philippines, the Republic of Korea, Singapore, Sri Lanka, Thailand and Turkey--to give just a partial listing--have all experienced declines of between 10 and 35 percent in the birthrate since the mid-1960's. A number of countries, including Bangladesh, Pakistan, Bolivia, Ecuador, and most of sub-Saharan Africa, have shown little if any fertility decline, however.

Despite fertility declines and family planning successes, a great need for family planning services continues to exist. According to reports of the World Fertility Survey:

- Half of the currently married fecund women in 15 countries stated they wanted no more children.
- In seven of eight countries where data are available, more than 25 percent of currently-married women with at least one child or currently pregnant stated that their last pregnancy was unwanted.

To this should be added many millions of women who choose to terminate their pregnancies, irrespective of the legal status of abortion.

FINANCING OF FAMILY PLANNING PROGRAMMES

Although information on funds allocated to or expended by national family planning programmes is imprecise, it is possible to conclude that with few exceptions, domestic support for family planning is modest. Data from 24 developing countries indicate that the average per capita expenditure on family planning was U.S. 36 cents. However, the two most populous countries in the world, China and India, have allocated major national resources to their family planning programmes. Until recently, China financed the totality of its highly successful programme. India has increased its national budget for family planning from \$66 million in 1974 to \$101 million in 1978.

International assistance for population activities, of which 75-80% is expended on family planning, increased from \$2 million in 1960 to \$190 million in 1971 to an estimated \$400 million in 1978. International assistance more than doubled between 1971 and 1978. The major donors, in order of the size of their contribution in 1978, the most recent year for which data are readily available, are the United States, Sweden, Norway, the Federal Republic of Germany, Japan, the United Kingdom, the Netherlands, and Canada. In terms of the percentage of total development support allocated to population activities, the three leading countries are Norway, Sweden and the United States. Globally, international population assistance averaged 2.2% of official development assistance in the 1970's, decreasing from 2.5% in 1971 to slightly more than 2% in 1978.

OVERVIEW

The past decade has witnessed a number of successes in the family planning field: with the exception of some sub-Saharan African countries and a few isolated examples elsewhere, policies favour family planning and governments are at least attempting to provide services. Innovative service delivery programmes have been attempted and shown to work. Contraceptive prevalence has increased worldwide and fertility has fallen quite dramatically in a number of countries.

The successes to date should not obscure the constraints which continue to exist. Funding of programmes in most countries is insufficient to meet the rising demand for services. Some religious and

other groups have mounted organised opposition to certain methods of contraception. The role of abortion in family planning remains highly controversial. Some radical political movements reject family planning as a palliative, while the North-South debate over economic development and the distribution of resources threatens to push the matter aside. At present the panorama is mixed. There are grounds for satisfaction but serious challenges remain. The experience gained over the past two decades gives substantial reason to expect further advances in the years ahead.

IV. CHALLENGES AND OPPORTUNITIES FOR THE 1980's

As reviewed in Section III, a transformation in human reproductive behaviour is underway in the developing world today. From small numbers just 10 years ago, today over 90 million people in Third World countries use some form of contraception to limit family size or space pregnancies. The growth of these numbers has been extremely rapid since the mid-1970's, and signs point to continued growth in the decades ahead.

While these trends grow out of profound social and economic changes, they also have been fostered and made possible by global efforts to extend the availability of contraceptive services, information and supplies. For this transformation to maintain its momentum and be extended to include the many people not practising family planning, governments, private programmes, and international agencies will need to respond to three major challenges during the 1980's.

Throughout the developing world today, many hundreds of governmental and non-governmental institutions operate family planning service delivery programmes. These programmes vary greatly in their scale of activity, their mode of operations, their quality, and their effectiveness. Some are highly effective in providing services, supplies and information in a timely, cost-efficient manner to people who need them. But on the whole, these programmes face numerous operational problems that limit their effectiveness. Many programmes have difficulty recruiting and training the type of medical, paramedical, and administrative personnel needed for a highly effective programme. The operation of clini-

cal services and existing outreach programmes often needs strengthening. Logistics systems are sometimes inadequate to maintain a constant supply of high quality contraceptives. Research and evaluation systems are frequently not sufficient to meet the needs of programme management. The quality of services and of communications with users is often inadequate. Some of the consequences of these limitations in the technical and administrative elements of programmes are low utilisation of services by prospective users and low continuation rates among people who do come to these programmes for services. Thus, the first and most immediate challenge for the 1980's is to improve the quality and to strengthen the operational capacities of public family planning programmes so they can provide their services more effectively and efficiently.

But, while essential to meet people's needs for contraception, a strengthening of the quality of programmes by itself will not be sufficient. Even with greatly improved technical and operational capacities, the coverage of present family planning programmes in most developing countries fails to meet existing needs. Furthermore, between now and the end of the century, the number of women of reproductive age will increase by 60%. If current rates of growth in contraceptive usage are maintained in the developing world, hundreds of millions of new users will be looking to organised public programmes as well as to private channels for help in meeting their birth planning needs. In addition, for a variety of social, economic, and cultural reasons, couples in some settings do not wish to control their fertility through the use of contraception. In places where low standards of health, nutrition, education, social security, and economic well-being prevail, family planning has much less appeal and validity as a means of improving the quality of individual and family life than it does in more developed settings. Under such circumstances, in addition to improving their coverage and services, family planning delivery systems must act in concert with other development programmes to promote improvements in income, education, social security, health, the status of women and other basic areas of life that fundamentally contribute to people's well-being and their desire for smaller families. Thus, a second major challenge for the 1980's is to extend the opportunity and benefits of contraception to the hundreds of millions of people who currently do not practise family planning

because of lack of access to services or lack of interest in using them.

How well the world community meets these two basic challenges will in large measure determine not only the size of the world's population in the decades ahead, but the personal aspirations and well-being of millions of people living in developing nations. But meeting these challenges will require much greater commitment to family planning on the part of governments and the international community in the 1980's. In a number of countries, governmental commitment to family planning is either absent or lacking on the level of effective policy and implementation. Family planning remains of relatively low priority in international assistance efforts, and population problems and concerns are not adequately incorporated into the work programmes and budgets of many international development assistance agencies. Thus, a third major challenge for the 1980's is to strengthen commitment to family planning on the part of both governments and the international community in a manner that will result in a greater allocation of resources and a more comprehensive and effective implementation of programmes.

The subsequent sections of this chapter discuss the major areas for action that need to be addressed if these three major challenges are to be effectively met. It must be stressed that these challenges, as well as the issues linked to them, are closely interrelated. Indeed, they are mutually reinforcing and to a large degree, successful implementation in one depends on progress in the others. Taken together, these interrelated lines of action seek to set forth an agenda of key issues and opportunities for the 1980's.

EMPHASISING THE USER'S PERSPECTIVE

All the effort and expense family planning programmes undertake to make their services available to people can be undermined if the services are provided in ways that do not adequately take into account the attitudes, needs and problems of actual and potential users of these services. Users' wants and needs obviously influence their acceptance and continuing use of family planning services and methods.

Unfortunately, there are indications that programmes are not sufficiently responsive to the perspective of users. The findings of the World Fer-

tility Survey and other studies show a sizable gap between the people's wishes to control their fertility--either permanently or for spacing purposes--and the level of contraceptive practice. Despite significant increases in contraceptive prevalence in many countries, low levels of acceptance and use are characteristics of many family planning programmes. In many cases, clinics and other outlets are used by only a small number of people, and low continuation rates reduce the cost-effectiveness of programmes even further. Although this low level of use of existing services sometimes results from a basic lack of demand for contraceptives, it often reflects a failure in designing and providing services in a manner that is appropriate to the needs and perceptions of people.

Many family planning programmes are initially constructed on centralised public health service principles, and they continue to reflect a high degree of managerial and administrative centralisation in the way they are designed and operated. To overcome these limitations, a number of programmes are now seeking new ways to improve the quality and extend the availability and acceptability of their services. At the core of their efforts lies recognition of the importance of providing services and using technologies that are appropriate and relevant to the needs, wants and life-styles of local people. These efforts are closely related to primary health care approaches, which are bringing new perspectives to meeting a broad range of public health needs through action at the community and individual levels.

To extend such efforts much more widely during the 1980's will require the development of commitment among family planning programme managers to fully incorporate users' perspectives into their programme activities. In most instances, basic policy decisions will need to be taken to conduct in-depth reviews of programmes from the user's vantage point to determine areas in which changes and adjustments ought to be made. This is unlikely to be successful if undertaken as a single effort, but rather must be understood and conducted as a long-term, continuing process.

This process of in-depth programme review from the user's perspective requires changes in the current methods of research and information gathering. New methods are needed to obtain information about people's perceptions in regard to all aspects of programmes--safety and effectiveness of contraceptives, risks and benefits involved, accessibility

and availability of services and their quality in terms of staff attitudes and performance. Qualitative and sometimes informal research approaches will be important instruments for achieving this. The participation of people in this exercise, not only as objects of the inquiry but also in its design and analysis, is essential to ensure that their perspectives are accurately understood. The focus of attention in identifying needs and problems must be broadened beyond the 'target' population to include the entire community. In many cases, local community groups can assist in these reviews, as well as in subsequent efforts to utilise the findings as a means of improving the programme and the services it provides.

As basic information from such reviews accumulates, programme managers, other personnel and users can jointly begin the critical task of identifying the most important deficiencies and problems that need correction. The actions required to more fully incorporate users' perspectives into programmes will, evidently, vary greatly from setting to setting depending on local circumstances. The range of potential action is large, but would probably include many of the following:

- Changes to increase the accessibility and acceptability of services through the more extensive use of local community-based outlets.
- Improvements in the way contraceptive methods are discussed with users in order to reflect more fully their own concerns and to enable them to knowledgeably select a method.
- Initiation of special orientation and training programmes for staff to increase their capacity to support, respond to and interact with local people.
- Changes in the composition of service delivery personnel away from specialists to local people trained on the job.
- Changes in programme evaluation to place greater emphasis on the user's perspective in the measurement of programme and staff performance.
- Establishment of effective feedback mechanisms for identifying users' problems and unmet needs on a continuing basis to facilitate effective responses from services.

COMMUNITY PARTICIPATION IN FAMILY PLANNING

The participation of communities in the design and operation of family planning services is essential if they are to be perceived by people as culturally acceptable and responsive to their needs.

Community participation provides family planning programmes with the opportunity to expand their outreach by tapping community resources and energies. It enables them to open up effective two-way communication channels with people and reinforces and contributes to other major programme directions described in this paper--emphasising the perspective of users, bringing about integration of family planning with other components of social and economic development, and improving the status of women.

In an increasing number of countries, community action programmes are becoming viewed by both local and national leaders as highly effective means of promoting family planning while at the same time contributing to broader community development goals. Both governmental and non-governmental family planning organisations are exploring various approaches to stimulating and supporting community participation. Efforts are underway in a number of places to implement such approaches on a broad scale.

Communities vary greatly in the ways they are organised and how decisions affecting community life are made. The most appropriate approach for bringing about community participation will be determined by existing social structures and prevailing cultural patterns. A wide variety of approaches, each with its own inherent strengths and weaknesses, is possible.

Some approaches have been based on the concept that a community's priorities and actions should flow from the needs identified and decided upon by the community itself without a significant involvement of government agencies or other institutions outside the community. Such participatory schemes usually limit involvement by outsiders to assisting community members to recognise and articulate their "felt needs." The initial outside involvement in the process is rapidly reduced as community members themselves take over the responsibility for action. These self-guided approaches have the potential of releasing enormous energy and commitment by ordinary citizens for pursuit of social and economic goals through a gradual process of social mobilisation.

Other community participation programmes have been primarily designed and implemented by outside groups, such as family planning programme officials

or trained rural development workers assigned by a government programme. These community-involvement efforts endeavour to bring about participation of community members through external direction, guidance and encouragement. These types of programmes usually seek to channel the interests and aspirations of the community in directions that are compatible with the interests and demands of the larger society that surrounds the community. At the same time, genuine commitment of community members to participate in a process of social change and development is sought. Such guided approaches have been effectively implemented at the national level in some countries, among them notably China and Indonesia.

Self-guided community participation schemes can result in much wider adoption and use of family planning. But this can also be very long in occurring in some instances if the community initially gives low priority to this aspect of family life and community welfare. The major strength of these approaches is the depth of cultural change and commitment to a new way of life that they are capable of engendering when they are successful.

Approaches that make use of outside groups to guide community mobilisation are not always easy to achieve, especially in settings where local structures for political governance are weak or diffuse or where local manpower for development work is very scarce. Community-level participation in such cases may be feasible only on a limited, highly-focused scale. Another inherent weakness in such approaches is that, at the extreme, they can depart from actual community participation and instead function as direct extensions of the centralised programme that seeks to implement them. In such circumstances, meaningful involvement of community members may be absent, and the strengths and benefits of community participation in overcoming social and cultural obstacles to family planning may be difficult to achieve. But when externally directed community-action projects are able to grant a substantial degree of autonomy and self-reliance to community members, broader social change can often result.

The major challenge for the coming decade is for family planning programmes in different cultures and political systems to find means for bringing about wide-scale involvement of local communities in their activities in ways that are compatible with local conditions and needs. To achieve this will require flexible, innovative leadership, much greater decentralisation of family planning programmes,

strong capacities for programme experimentation and, in most settings, ability to work closely with a variety of non-governmental organisations.

INTEGRATING FAMILY PLANNING WITH OTHER COMPONENTS OF DEVELOPMENT

Since their inception, family planning programmes have been linked to varying degrees with health services, particularly maternal and child health. More recently, both health and family planning, separately and together, have become part of various other aspects of community development.

One of the clearest messages of the 1974 World Population Conference in Bucharest was that if family planning is to make a meaningful contribution to development it must be provided as an integral part of broader socio-economic development efforts. And one of the clearest messages of the 1978 Conference on Primary Health Care in Alma Ata was that people themselves must take an increasingly large responsibility for their own health problems and work towards the prevention of disease through community development. Neither health nor family planning can be isolated from other concerns such as nutrition, sanitation, home economics, child care, education and income generation.

Throughout the 1970's, different approaches have been pursued, often on an experimental basis and with varying degrees of success. Within both governmental and non-governmental sectors there have been attempts to introduce family planning as a component of other community services, such as health, nutrition, non-formal education, and agricultural extension. Conversely, an extremely important development in some countries has been the addition of other elements, such as nutrition and certain health measures, to established family planning programmes. In addition, a number of successful efforts have been made to link family planning concerns with the interests of such community organisations as cooperatives and women's groups.

While these various approaches offer promise, in practice integration has proved difficult to accomplish effectively. It is one thing to decide that various components of development belong together, but quite another and much more difficult task to initiate and maintain a significant measure of intersectoral collaboration. Functionally, integration has several managerial and administrative problems. These include differences in programme

priorities and criteria for evaluation between the collaborating agencies. The allocation and control of resources have raised difficult problems, as have questions relating to the recruitment, training and deployment of personnel. The experimental nature of integrated projects has made them expensive to establish, especially where few development services exist.

Nevertheless, the integration of family planning with means to improve community and family life remains an essential objective for the 1980's. A key challenge facing both family planning programmes and programmes in other development sectors is to find practical ways of achieving this objective.

The most promising avenue for bringing about integration during the 1980's will be to pursue a decentralised approach, identifying and meeting needs for services at the community level and capitalising on local institutions. Active participation by communities, along the lines described in the previous section, offers the possibility of overcoming some of the underlying administrative obstacles to integration.

One important route to be followed is to effectively incorporate family planning into primary health care as one of its basic components. Primary health care will be a key to better health in developing nations and an essential part of community development during the coming decade.

At the same time, other opportunities for integration need to be actively sought by family planning programmes, since family planning extends beyond health concerns. These may include mobilising, encouraging and supporting professional groups, such as teachers and extension workers, and other groups, such as youth organisations and trade unions. At the local community level, a wide variety of groups that are part of the existing social infrastructure need to be brought into integrated programmes. Government programmes can make use of the greater diversity and energy of private organisations concerned with development to provide help to local community groups exploring different forms of integrated services.

Most integrated projects so far have been conducted on an experimental basis and it is difficult to determine which approaches are more likely to succeed and to be more easily replicated. New ways must be found for converting successful approaches to broad-scale programmes. An essential element in this process will be building up managerial and technical skills capable of overcoming the numerous

operational problems associated with combining family planning with other development services. At the same time, operational research and evaluation efforts need to be strengthened to obtain necessary data on the cost-effectiveness of various integrated approaches. All these actions require a strong policy commitment at the highest level to influence development policies and plans and to ensure the allocation of adequate resources for integrated approaches.

MALE AND FEMALE ROLES IN FAMILY PLANNING

In many countries women are restricted in their ownership of property, their ability to marry and divorce, their freedom of movement and employment, and their access to education and other resources. These social and economic restrictions adversely affect the status of women in society and within the family. They also strengthen existing cultural pressures for women to define and concentrate their lives around their maternal roles.

One outcome of these limitations is that women do not for the most part have the opportunity to participate fully in national development. Women often have little control even over decisions that shape the course of their own lives. Paramount among these are decisions related to fertility, which are often made or are strongly influenced by men. This applies at the level of couples and families and, more broadly, in the design and delivery of fertility regulation services.

Improving the status of women through legal change, greater access to education and income-generating opportunities, and fuller participation in community life are key factors in redressing this imbalance. New options for women not only help increase their capacity to make decisions, but also encourage changes in attitudes that underlie child-bearing and fertility behaviour on the part of both men and women.

One of the most tangible obstacles to more equitable sharing of responsibility for family planning among men and women is the limited availability of contraceptive methods for men. There is an urgent need to increase service and supply outlets that provide male methods. More personnel trained to provide information and counselling reflecting male concerns about family planning may encourage greater utilisation of services by men. In addition, there is a continuing need for new technolo-

gies to expand the range of methods that men can use. Much greater commitment by the research community to improving male methods is essential if this is to become a reality in the future.

Communication with and among men about family planning is likely to be a critical factor in promoting male involvement. There is therefore a need to identify male community networks where family planning can be discussed, enlisting the support of male community leaders.

One of the principal requirements is increased and improved family life and sex education for both adults and young people, providing opportunities for men and women to consider male and female roles in society, their attitudes to sexuality and fertility, and the joint responsibilities of parenthood. Efforts to work with adolescents could be particularly fruitful in opening up dialogue between men and women about their roles in the home and society.

EXPANDING THE AVAILABILITY OF FAMILY PLANNING

With sufficient time, determination and expense, most people living in developing countries can obtain access to at least a partial range of contraceptive supplies, information, and services by travelling to centres where these are offered. But if availability is defined in more practical terms--nearby presence of an outlet that offers services, information and supplies without major cost or inconvenience--then the majority of people living in developing countries still have only very restricted access to family planning. This is particularly the case for many people in countries that offer only minimal or no public family planning services; for populations living in rural areas who are not reached by service networks; for impoverished groups living in slums at the margins of large cities; and for such special groups as youth, refugees, indigenous and tribal populations, and certain disadvantaged groups.

The most urgent need for action is in those countries that do not now offer family planning services or do so only on a minimal basis. They must take steps to add these to their governmental health and development services. Formal policy commitment at the highest levels of government will be needed to achieve this, followed by the commitment of adequate financial and human resources to develop and operate effective programmes.

In those countries where family planning programmes exist, new ways need to be devised to expand the provision of supplies and services beyond conventional clinic-based health networks in order to reach people who do not now have ready access to these networks. Different types of community-based distribution (CBD) systems offer one important way of bringing about rapid expansion of services and supplies to outlying rural areas. Outreach programmes are urgently needed to serve special groups, such as refugees, migrants and tribal or indigenous populations. Such specially designed outreach programmes are particularly needed to provide information, counselling and services to young people who may want help in avoiding pregnancy but who are unwilling to come to clinics for assistance. Also, outreach services tailored to meet the special problems of married adolescents are needed, especially in countries where very early marriage is common.

But these limited ways of expanding availability will not be sufficient to meet the needs of people living in rural regions and poor urban areas in many developing countries. As discussed above in the section on "Community Participation in Family Planning," a key approach to expanding availability of family planning is through broader forms of community participation. Medical attitudes that stand in the way of involving non-medical personnel and non-medical outlets in the provision of contraceptive services will need to be changed to encourage much more pluralistic, decentralised approaches to providing services at the community level.

In countries with market economies, these approaches can be supplemented by greater utilisation of commercial retail outlets. One way this can be accomplished is through much wider use of publicly-subsidised commercial retail sales projects. Such quasi-commercial systems have been successfully developed, financed and operated by family planning programmes in a number of countries.

A second way to accomplish this is through stimulation of drug companies and pharmaceutical distribution networks to extend commercial systems of services and supplies to low income groups. In most countries this will require changes in the area of trade, commerce and drug regulation. These will need to appropriately protect the needs and interest of the public, while retaining the inbuilt entrepreneurial initiative, flexibility, and appeal that commercial systems are capable of providing. In many countries, use of the private sector in this

way can greatly strengthen national self-sufficiency in the provision of family planning services.

Another area for action in the coming decade is to remove legal and administrative obstacles to the distribution and use of birth control methods. In a few countries, family planning information, services and supplies are legally prohibited. In many others partial restrictions are in effect which severely curtail the availability of family planning to certain groups of people such as youth or unmarried women. Legal and regulatory barriers block the importation of contraceptive methods in numerous countries, causing very significant restrictions in the range of methods that can be made available. Finally, wider availability of birth control methods and service is often prevented by local prescription requirements, advertising and distribution regulations, and medical standards and guidelines limiting who may deliver and who may receive different types of services. Legal and administrative obstacles to family planning exist to varying degrees in most nations, and in some parts of the world there is a risk that they may become more prevalent as a result of political and religious pressures. There is no doubt that a major political challenge facing family planning programmes in the 1980's is to work towards removal of these obstacles wherever possible and to prevent new restrictions on contraceptive availability from being imposed.

STRENGTHENING PROGRAMME MANAGEMENT

Of all the factors that will determine the progress made in the field of family planning in the 1980's, none is likely to be more centrally important than programme management. Experience, both positive and negative, in a number of countries has demonstrated the tremendous impact that management can have on the performance of programmes. Managers of most family planning programmes are acutely aware of shortcomings in this area and in many countries they have made improvements in programme management one of their priority objectives.

One of the most basic steps that needs to be taken is to strengthen programme planning and priority-setting, including diagnosis and solution of major underlying problems that prevent programmes from attaining their basic goals. This capacity to identify and to solve strategic problems flows from four interrelated elements: the skills and abilities of the senior management personnel of the programme,

its organisational structure, its planning procedures, its resources for conducting experimentation.

Among these four, the quality and experience of the senior managerial staff is likely to be the most crucial. Unfortunately, able managers are too often in short supply. In many countries, individuals who have training, skills and experience in management are at a premium, especially for public-sector programmes where salaries are usually not competitive with those offered by private companies. This problem is sometimes compounded when appointments of senior management personnel of family planning programmes are not sufficiently based upon managerial qualifications. Governments face numerous competing demands for management skills in different sectors. If the management capacity of family planning programmes is to be strengthened during the 1980's, national governments will need to give much higher priority to these programmes and to ensure that the best available managers are recruited to lead and operate them.

Operational and administrative aspects of programmes also need to be improved. This requires the application of professional management approaches to technical and financial planning, supervision, training, recruitment, and the administrative functions of purchasing, distribution, inventory control, accounting, budgeting and routine personnel management. The use of good management practices in all of these is essential for programmes to efficiently perform their operations and effectively deliver services and supplies to people.

The strengthening of programme management skills in these areas must be carried out in a manner compatible with local conditions and needs. In most countries, greater reliance on local private-sector managerial resources including management institutions, consulting organisations and schools of business is possible. Where such potential sources of relevant knowhow and skills exist, they need to be much more actively tapped for help in strengthening public family planning programmes in the countries where they are located. Their expertise can be used to assist programme managers to further develop staff management skills and to diagnose and find solutions to chronic operational and administrative problems. Where local resources are inadequate, it may be useful to employ technical aid from management consultant groups from outside the country. A number of countries have found it valuable to make use of the experience and advice of those nearby

family planning programmes that have developed strong management expertise of their own.

A third way in which management of family planning programmes needs to be strengthened poses the greatest challenge and difficulty because it requires the development of completely new directions and approaches. If family planning programmes are to greatly expand the availability of services during the coming decade, in most countries they will need to make use of new forms of management geared to this task. The current highly centralised patterns of organisation, usually linked to a clinic-based service delivery system, will need to be supplemented by highly decentralised organisational structures especially designed to foster community participation and decision-making at local levels. These new patterns of organisation will need to foster pluralistic programmes and approaches in family planning and will need to give more attention to the perspectives and needs of users. A number of countries have begun to find ways of structuring their programmes to achieve such decentralisation, and many non-governmental organisations in different countries stand ready to work with national programmes at the community level.

PROGRAMME EVALUATION AND EXPERIMENTATION

As noted in the preceding section on programme management, the capacity to gather and analyse relevant information is an essential element for strategic planning and priority-setting by family planning programmes. In its fullest sense, this capacity includes both informal means of gathering and analysing needed information and formalised systems of programme evaluation, research and experimentation. This capacity lies at the heart of a programme's abilities to recognise and address its problems.

Almost without exception, family planning programmes of every kind make use of some type of service statistics to provide a regular flow of data about programme performance. These statistics systems monitor the quantity and kinds of services a programme delivers and the numbers and types of people it serves. Unfortunately, these systems have a number of weaknesses that need to be overcome if programme management is to be strengthened during the 1980's. Often, they fail to provide managers with accurate, timely information. They usually emphasise such statistical indices as numbers of new acceptors, volume of supplies distributed, and

number of visits to outlets. While these indices provide useful data for managers, they fail to measure many of the key outputs that can determine the success or failure of programmes. These include staff performance, user satisfaction, and continuation of contraceptive use. Because data on these outputs are frequently lacking, managers often find it difficult to correctly diagnose major flaws in their programmes and find solutions to overcome them.

The types of statistics collected by evaluation units in family planning programmes need to be supplemented by other measures to take these key outputs into account. This is only likely to happen if managers themselves begin to play a more active role in deciding what information will be useful for them and what statistical indices and qualitative data will provide this. Programme evaluation units need to find new ways of producing such data on a regular and timely basis. This will require not only improved service statistics, but also sample surveys, qualitative research emphasising the perspectives and participation of users, and other types of special-purpose diagnostic and evaluation research.

Improved capacities for experimentation and action research will be especially vital in the coming decade as programmes seek to place greater emphasis on the perspective of users, to bring about community participation and to devise workable means of integrating family planning with other development activities. All of these entail new approaches, and for programmes to be successful, it will be critical to test different ideas and approaches on a small scale in order to learn what works best.

But few family planning programmes today are well equipped for conducting action research and programme experimentation. Even programmes that have strong service statistics units rarely possess capabilities for operations-style research that undertakes to answer practical management-related questions. Aiding programmes to design and conduct such action research is an area in which non-governmental technical organisations, both national and international, have traditionally played an important role in the family planning field. Also, in some countries, private marketing research firms possess extensive expertise and experience in carrying out applied social research, which they are often able and willing to make available to family planning programmes. These different kinds of assistance need much more intensive utilisation in

order to train local programme staff to conduct action research and to build working partnerships between programmes and local expert organisations.

IMPROVING TRAINING AND HUMAN RESOURCE DEVELOPMENT

Through the course of the 1980's the rapidly growing need to expand existing programmes will require the recruitment and training of tens of thousands of additional staff to manage programmes, conduct and evaluate research, undertake communication activities, select and introduce birth control techniques, and provide services. Family planning programme managers need to develop plans for large-scale training and utilisation of a wide range of family planning workers, and to obtain the necessary technical and financial resources to implement them.

At the management level, there is a continuing need for training of many additional staff, not only for central management roles, but at regional and local levels as well, so as to enable programmes to effectively decentralise their operations. Emphasis will need to be placed on developing middle-level management and supervisory skills through special in-country courses and through technical cooperation among the developing countries (TCDC). New management approaches can only be introduced by a managerial cadre who can modify existing organisational and administrative structures to meet local needs.

The training and retraining of service personnel, including physicians, midwives, nurses and other health workers, will also need to be vastly expanded at the national and local levels. These providers need to increase their understanding of the technical aspects of family planning and, at the same time, learn to communicate appropriate information to individuals in ways that are easily understandable and are relevant to people's needs. New training techniques are required to enable service personnel to gain these skills which are often not adequately developed.

An even larger number of workers will be required to serve at the key points of interaction with communities at the local level. These are the primary health care workers, village volunteers, family planning workers, community distribution agents, and others. Extensive training efforts are needed, incorporating new concepts and techniques, to effectively take into account the user's perspective, new communication approaches, and means to enhance community participation and integration with

other development activities. Much of this training must be done at local levels, with a degree of flexibility not presently found in most training programmes. Again, TCDC needs to become a key element in the exchange of innovative approaches.

A fourth category, the traditional medical practitioner, has become increasingly important in a number of programmes, especially in Asia and Africa. This includes traditional birth attendants, ayurvedics, and many other traditional healers and practitioners. As a group, these individuals provide much of the health care presently offered to people in the developing world and therefore represent an extensive human resource which is largely untapped by family planning programmes. It is not easy to link formal programmes with these groups. Special ways of training traditional practitioners and of incorporating them into different aspects of family planning information and service programmes have been developed on a small scale, but their full potential has not yet been realised.

For all these training requirements, an extensive cadre of qualified trainers must be developed, as well as curricula appropriate to local needs. With the deployment of new family planning workers, large numbers of supervisors need also to be trained, not only to monitor field work, but to provide effective support and retraining for local personnel.

Resources for this crucial training function will, in most cases, need to come from the national and local level, although international support also needs to be strengthened. Especially critical areas will be training in management, training of specialists in both communication and technology-related areas, and most important, further development and refinement of training methodologies, emphasising participatory rather than didactic approaches.

USE OF COMMUNICATION IN FAMILY PLANNING PROGRAMMES

Provision of information and education has been accepted as an important component of family planning programmes since their inception. Activities broadly called communication serve a number of different purposes: they provide people with information about the contraceptive methods they use or are considering using; they seek to inform and persuade policymakers about the need for population policies and family planning services; and they attempt to educate, encourage and motivate people to

adopt family planning. Overall, family planning communication aims to increase knowledge, change attitudes, and alter behaviour in the area of fertility through provision of information, educational programmes, and different kinds of promotional activities.

Despite a wide diversity of programme efforts and considerable progress over the past two decades, family planning communication suffers from numerous weaknesses. Many of these arise because of confusion about the purposes and functions of various communication activities. Motivation and promotion campaigns are often not distinguished from programmes whose function is principally informational.

Motivational efforts have sometimes concentrated too narrowly on messages of dubious validity, such as claims of a direct economic benefit to be gained by family planning, or too exclusively on particular methods, such as the pill or sterilisation, or too selectively on certain types of service outlets. Programmes designed to communicate information about contraceptive methods have frequently focused instead on promoting family planning or specific methods. Such programmes have also been deficient in many instances because they have not sufficiently taken into account low levels of literacy and education. For example, complicated medical terminology is often used in discussing reproductive function and methods of birth control. In general, family planning communication has suffered from both a "top-down" approach and over-emphasis on persuading or motivating people, which frequently results in a short-lived acceptance of family planning.

If these weaknesses can be surmounted, communication can overcome many of the social and cultural constraints to family planning by helping people learn about family planning and its relation to family health and well-being in a full, accurate and personal way. Only through such understanding can people be comfortable in bringing this new and sometimes complicated area of behaviour and technology into their lives.

A number of steps can be taken to improve and strengthen family planning communication during the coming decade. Personal counselling, whether in the clinic, at CBD outposts, or during house-to-house visits, needs to be much more strongly emphasised. New techniques for combining the use of mass media, radio in particular, with carefully integrated group and personal communication at the community level also offer special promise for increasing knowledge

and understanding of family planning during the 1980's.

These approaches involve communities much more extensively than in the past as active partners in information and education activities so that communication becomes a truly two-way process. Community programmes, many of them pilot projects on a modest scale, have shown that the use of group dynamics--either through special meetings or through permanent community organisations like Mothers' Clubs--can offer an effective vehicle for full and open communication and discussion at the village level. Family planning workers involved in such communication efforts need to become facilitators rather than "message carriers."

Communication components need to be more effectively integrated across all sectors of development. Such integration needs to be achieved in the training of village level workers and outreach personnel associated with various development programmes, as well as in educational activities of community co-operatives, agricultural extension projects and other programmes.

The effectiveness of family planning communication activities could also be enhanced in many cases if they were better integrated at an operational level with other family planning service activities. Too often, those engaged in family planning communication and the providers of family planning supplies and medical services carry out their work almost independently. Closer collaboration and joint efforts between these groups are needed for family planning communication to yield its full value for programmes and the people they serve.

The next generation of parents presents a special challenge. Exposure to the risk of adolescent pregnancy has increased everywhere in the world. It is an acute problem among unmarried young people, and it is also a problem in societies with a tradition of early marriage because of the health risk of early adolescent childbirth. But sex and family-life education and counselling for youth are only slowly being introduced into school curricula, and few out-of-school programmes exist to reach and involve the young. Preparing young people, within and outside the school system, for their roles as sexually mature adults and responsible parents is a major task for the '80's.

One of the basic steps that can be taken to strengthen family planning communication efforts is to make better use of research and evaluation techniques. There is great need to conduct careful

prior research among the people for whom communication programmes are being developed to find out what types of programmes and materials effectively take into account their attitudes and needs. Extensive pretesting and step-by-step refinement of materials and approaches is required to ensure that the design and content of such programmes address people's real needs. At a practical level, the use of action research to develop communication activities before they are launched will entail close work with local communities as well as users and providers of family planning services. Existing levels of knowledge and understanding will need to be identified to provide an accurate basis for the development of relevant concepts, approaches, themes and materials. Once programmes have been put into operation, it is important to take steps to periodically evaluate their effectiveness. Although often difficult to design and carry out, evaluation studies are essential for determining which types of programmes are effective, which are not, and how future efforts can be improved.

MAKING OPTIMAL USE OF AVAILABLE TECHNOLOGY

Currently there are about 17 basic birth control methods, as noted in Section III. Unfortunately, all have certain deficiencies and drawbacks, and these are a major cause of low acceptance and poor continuing use of contraception in many settings. A continuing challenge facing family planning programmes is how to make optimal use of these available birth control technologies in a manner that minimises their shortcomings.

There are several ways programmes can do this. The first is to offer a wide range of technologies. Such a "cafeteria" approach gives people many choices and enables them to find a method which suits them best. However, many programmes find it difficult to deliver a comprehensive selection of methods--indeed, many find their resources stretched in offering even four or five methods. Generally, those selected are modern, medically-oriented methods, such as the oral contraceptive, IUD, injection, and sterilisation. While many programmes also include condoms, few offer barrier methods for women or instruction in such simple, often traditional techniques as withdrawal, abstinence, or prolonged lactation.

Expanding the range of methods offered by programmes is a more difficult challenge than is some-

times recognised. Over 100 variants of the 17 basic birth control methods exist, and programmes need a technically sophisticated system for reviewing these and selecting those best suited to local needs and conditions. Programmes need to keep in touch with the vast and growing body of technical information about effectiveness, side effects, long-term safety, mode of use, acceptability and other relevant features of the major methods. National regulatory authorities need to work with programmes to carry out local risk/benefit assessments, provide regulatory clearances, and establish appropriate guidelines. Effective procurement and logistics systems must be in operation to assure a steady flow of supplies. For many methods, extensive training of medical and paramedical personnel and organisation of clinical services is needed. Thus, to select and efficiently supply a dozen or more different types of birth control methods will require for most programmes an extensive build-up of technical and managerial capacities in areas related to contraceptive technology.

But technical limitations are not the only reason programmes find it difficult to provide a full range of methods. A variety of cultural, religious, professional and legal barriers block contraceptive use in different countries. To some extent, these affect the general availability of family planning services, as discussed under "Expanding the Availability of Family Planning" above. But frequently they focus on particular methods. In some countries, for example, the use of oral contraceptives or IUDs has been prohibited or severely limited for reasons having little to do with their safety or effectiveness. The distribution of condoms has been limited or barred in some countries because of cultural objections to this method.

Sterilisation for both men and women has been widely subjected to restrictions. The irreversibility of sterilisation procedures and their surgical nature run counter to some ethical and religious beliefs. Despite such objections, many countries have permitted sterilisation services to be made available and have allowed individuals to make their own decision about using these services. In other countries, however, the use of sterilisation is prevented or restricted by governments and health authorities because of religious and ethical concerns.

There is no doubt that cultural and religious objections are most intense and widespread in relation to different types of abortion procedures.

Because such techniques act on the early embryo rather than on the sperm or egg, they raise fundamental ethical and religious questions both about when life begins and whether its termination can be justified. Many governments, especially in developing countries, have been unwilling to permit the use of abortion services, either through private health care systems or family planning programmes. But nonetheless, women who are not able to obtain or effectively use contraceptive methods frequently resort to abortion, and as a result it is one of the most widely practised means of birth control. Since much of this use of abortion is in countries where it is illegal, these women often face a high risk of death and morbidity due to the inadequate medical quality of the techniques employed.

For these last two controversial technologies, each country clearly needs to arrive at its own national consensus regarding the balance to be struck between social needs and attitudes, religious beliefs, and individual freedom of choice. A major challenge at the national level for family planning programmes during the 1980's will be to find ways of making available all safe and effective birth control methods to people who want to use them in ways that respect overall societal beliefs and concerns.

If programmes are to make optimal use of available technology during the 1980's, they will need to address a number of strategic issues related to the supply of birth control methods. Modern birth control methods are expensive in relation to levels of family income in many developing countries. For this reason, a major share of foreign aid in the population field over the past two decades has been used to pay for commodities. But there is serious doubt that this pattern of subsidisation can prevail at the same level throughout the 1980's. This is especially so because of the much larger numbers of users anticipated during the next two decades as well as the increased cost of supplies.

If the share paid by foreign aid monies declines, then either national governments or local users will need to pay more. Under such circumstances, local manufacture of contraceptive supplies by governments and greater participation of the local commercial sector in supplying contraceptives become options that need careful evaluation. During the coming decade, governments of developing countries will need to work closely with international development assistance agencies and private sector companies to develop long-range plans to meet their

birth control technology needs. These plans will need to specify the most suitable combination of local manufacture, purchase, and commodity grants to meet long-term supply needs at prices that local people can afford.

Another equally important step in making optimal use of available technology concerns the provision of information about methods to users. Numerous studies have shown that information is a key to the adoption and use of technologies, particularly when they raise important personal questions. Since birth control technologies can have serious health consequences or interfere with sexual behaviour, they often cause personal anxieties and concerns. Readily available, reliable information about different methods helps people to dispel unwarranted fears, to identify valid concerns, and to arrive more confidently at decisions about contraceptive use. To the degree that programmes are successful in providing intensive instruction and counselling about methods in a way people trust and understand in their own terms, both the quality and extent of contraceptive practice can be tremendously enhanced using the birth control techniques that are available today.

PROSPECTS FOR IMPROVED TECHNOLOGY

Researchers in both private companies and public-sector contraceptive development programmes are currently working on well over two dozen potential new contraceptive methods. Several of these are near or at the point of being introduced into family planning programmes. The new methods most likely to become available within the decade are: new types of IUDs, new versions of oral contraceptives, subdermal contraceptive implants, contraceptive vaginal rings, improved long-acting injections, and, possibly, new types of barrier contraceptives for women.

Three new varieties of IUDs are likely to emerge: highly effective, long-lasting copper IUDs; different types of drug-releasing IUDs that cause less menstrual bleeding and possibly less cramping; and postpartum IUDs specially suited for insertion immediately following delivery. The new oral contraceptives replace current steroids with new formulations that cause fewer metabolic changes in the body. The implants now being introduced consist of six subdermal capsules that release a contraceptive steroid for over five years. They offer a new, highly effective reversible contraceptive method.

Side effects of the implants are similar to oral contraceptives, except for slightly more bleeding irregularities. Improved, biodegradable implants are likely to become available by the end of the decade. Like the implants, the contraceptive ring releases contraceptive steroids which are absorbed by the body through the vagina. A woman inserts the ring and leaves it in place for three weeks, then removes it for a week so menstrual bleeding can occur. Side effects are very similar to those of the pill. Improved injections will offer one to three months of highly effective contraception. Cervical caps, self-fitting diaphragms, and a variety of other physical and chemical vaginal barrier contraceptives are under development, and one or more of these may emerge as effective and acceptable new methods.

Each of these prospective methods has its own particular set of advantages and drawbacks. Each offers certain potential improvements over existing methods. For the IUDs, added effectiveness, suitability for use among postpartum populations, and reduced menstrual bleeding are likely to be the advantages. Because they cause fewer metabolic alterations, the new oral contraceptives will offer the prospect of fewer long-term side effects. The implants provide up to five years of highly effective, reversible contraception with side effects similar to those of the pill; they are seen as a potentially very well-accepted alternative to female sterilisation. The contraceptive ring provides effective monthly contraception by a different route than the pill and has proven highly acceptable to some groups of women in initial trials. Since its use does not require the involvement of medical personnel, it is viewed as having the same potential for non-clinical distribution as the oral contraceptive. Improved injections will perform much the same as current products but they will employ steroids that exhibit less animal toxicity. Less disruption of menstrual patterns may also be achieved with some of the new versions. New female barrier contraceptives may permit this type of contraception to be used with higher effectiveness and greater user acceptability along with the additional advantage of not requiring medical personnel for their delivery.

A wide variety of other methods are also under development, a number of which could have a dramatic impact on birth control practice if they become available. Those which offer the greatest potential improvements from the user's vantage point include a

pregnancy-preventing vaccine for men or women, a reversible contraceptive pill or injection for men, and a pill or tampon used by women to induce menses following a missed period. These and other potential new methods are still at early stages of development and are unlikely to become available in less than a decade. Several other potential new methods, such as non-surgical methods of female sterilisation, improved condoms, and monthly contraceptive pills, might be developed sooner, but technological problems and low levels of scientific commitment make this unlikely.

Many of the improved methods now being developed with a high likelihood of success could yield important benefits for family planning programmes and the people they serve. For this to occur, however, programmes will need to meet the following two challenges.

The first, as discussed in the previous section, is the need to greatly strengthen local capacities for introducing and making optimal use of birth control technologies. The new methods will undoubtedly place an additional burden on the technical and financial resources of programmes in this area. Without extensive strengthening of capacities and careful planning and management of resources, future contraceptive techniques are unlikely to be successfully introduced in many countries and, indeed, in some instances, could dilute the ability of programmes to deliver currently available methods. Each family planning programme needs to carefully evaluate the likely benefits to be gained from the use of new methods and the costs and feasibility of introducing them. Programmes should selectively introduce only those methods which offer significant advantages within the context of local needs.

The second challenge is indirect. If family planning programmes hope to make use of improved birth control methods in the 1980's and beyond, increased financial support of contraceptive development work will be needed. The amount of funds now being devoted to this applied research activity, about \$20 million annually, is much too small to permit completion of the development of even the most promising new methods. Funding has been declining in recent years, and public-sector contraceptive development programmes are experiencing serious financial difficulties.

Additional funding is unlikely to be forthcoming unless family planning programmes actively communicate to donor agencies their belief that improved new technologies can substantially improve family

planning practice in their countries. Programmes need to review the methods currently being developed to identify those likely to offer significant benefits to their users. They need to participate actively in the development and testing of these methods in their own countries. They also need to encourage donor agencies that provide support for contraceptive development to expedite the rapid development of these methods. This will require greater coordination among the organised contraceptive development programmes and joint planning among the donors, greater technical coordination, and, above all, substantial increases in funds for this work.

USE OF INCENTIVE AND DISINCENTIVE SCHEMES IN FAMILY PLANNING PROGRAMMES

Fertility behaviour is influenced by personal aspirations and the social values and norms prevailing in the community. If these do not coincide with the government's perception of the needs of society as a whole, governments may take action to influence fertility decisions. About thirty governments have established incentive and disincentive schemes in support of pro-natalist or anti-natalist policies. These include a wide range of measures from rewards for accepting particular methods and benefits for small or large families to payments to programme workers for performing certain tasks.

The use of some incentives and disincentives creates controversy mainly because they constitute a form of pressure on individuals and couples and can result in curtailments of benefits and rights. The key issues facing family planning programmes in the 1980's in regard to the use of incentives and disincentives are how compatible are they with human rights and with social norms and values; how feasible are they to implement in terms of cost and operations; and how effective are they as policy measures?

It is not possible to establish universally applicable yardsticks for the ethical acceptability of various incentives and disincentives since this acceptability is determined by the extent to which they conform to social objectives and value systems. This becomes a crucial element when there is a potential conflict between individual freedom of choice and societal needs. Such a conflict may arise not only at the national level but between the rights of individuals and the rights of the immedi-

ate community in which they live. Especially where a decentralised social and administrative structure exists, the community's protection of its own rights may take the form of "peer influence" and values may change radically under strong social pressure. This has been an important element in the national programme in China where the small family norm is consistently reinforced at the community level and the interests of the individual and society are regarded as identical.

For each country, the point where individual rights should give way to the common good is difficult to establish. As a guideline, the 1974 Tunis Symposium on Law and Population has recommended that any benefits and services provided as incentives should be in addition to the benefits and services to which all persons are entitled as a basic human right and that any benefits or services withheld or withdrawn as disincentives should not conflict with the enjoyment of basic human rights.

Some anti-natalist disincentives entail restrictions on health services and social welfare benefits. Furthermore, they sometimes affect not only parents but also their children, especially those born after a specified family size has been achieved. Withdrawal of maternity benefits, including paid maternity leave, restrictions on hospital care and job and promotion opportunities may have significant effects on the health of the mother and the baby and the welfare of the whole family. Reduced education and employment opportunities and food rations for children of a certain birth order are more directly related to the basic human rights of these children.

The ability to make a choice about family size is restricted when opportunities in other essential aspects of life such as housing or employment are reduced. Economic incentives to promote the acceptance of a particular method or the small family norm may have discriminatory effects in the society. The perceived value of the reward offered is relative to the financial status of the family and may have a more significant effect on low income families than on wealthier ones.

On the other hand, the enjoyment of basic human rights also depends on the capacity of the state to provide its citizens with the means of exercising these rights. A nation's ability to increase food production, to provide additional education, health and housing facilities and to create new job opportunities for a rapidly increasing population may be limited. Although reducing the population growth

rate does not solve immediate development problems, it may ease the burden for the future. When provision of contraceptive information and services does not bring down the fertility level quickly enough to help speed up development, governments may decide to limit the freedom of choice of the present generation so that future generations may have a better chance to enjoy their basic rights.

The feasibility of incentive and disincentive schemes is affected by the availability of sufficient resources to finance monetary schemes and by the existence of an administrative machinery to operate them efficiently. The cost of benefits offered as incentives may become a burden on the economy. Cash payments or other rewards to programme workers, especially when linked to the achievement of certain targets, may be open to fraud or unacceptable exertion of pressure on people and may therefore require close supervision. In the long run, incentives designed to increase workers' efficiency such as training opportunities leading to higher status and promotion based on the quality of performance, as reflected by the obvious satisfaction of users, may have a greater influence on improving the acceptability and effectiveness of the programme.

The ability of these schemes to reach a sufficiently large proportion of the population to make an impact on the national fertility level may also be limited. Income tax allowances, for instance, can only be effective for the taxpayers. Similarly, measures relating to social welfare benefits are not likely to make a substantial impact if a large majority of the population does not have access to them.

The long-term effectiveness of incentives and disincentives in influencing fertility patterns has been inadequately documented. Recent analyses indicate that higher fertility rates in Czechoslovakia are partly due to the comprehensive scheme of health and social benefits to large families which has been in operation for more than ten years. In China and Singapore incentives and disincentives are believed to have contributed to rapidly declining fertility rates.

The effectiveness of incentives and disincentives in influencing individuals to change their fertility behaviour depends on the extent to which they provide genuine alternatives to existing fertility values. Pension schemes designed to benefit those with smaller families are intended to compensate for the old-age security traditionally pro-

vided by children. Other incentives such as housing concessions for smaller families may help to reinforce changes already taking place as a result of urbanisation and modernisation.

The use of incentives and disincentives in family planning programmes and the ethical and operational questions related to their use will continue to be an important issue in the 1980's. The continuing rapid growth of population, with the varied pressures it imposes on struggling economies and social problems, may lead to adoption of these schemes by more governments or to the reinforcement of existing schemes by additional measures.

By limiting freedom of choice, the use of incentives may undermine the approach described in this paper to make the user's perspective central to family planning programmes. In the long run, this approach may well be the most effective incentive for family planning. The crucial question is whether governments can afford to wait.

STRENGTHENING COMMITMENT TO FAMILY PLANNING

During the past two decades there has been an impressive increase in the number of governments that have formal policies in support of family planning. Over 90% of the population of the developing world now lives in countries that have such policies. In many countries, however, governmental commitment to family planning may not be as strong as their formal policy statements suggest. Several Asian governments have backed up their policy statements by establishing effective national programmes and allocating significant national resources to their implementation, but this is not true of most Latin American countries or in those African and Middle Eastern countries that formally support family planning.

Current levels and distributions of health expenditures also raise doubts about the degree of effective commitment to family planning in many developing countries, even when economic constraints are taken into account. Family planning programmes usually receive only a small part of national health expenditures. All too frequently, half or more of total government health budgets are devoted to a few urban hospitals and clinic-based medical systems which do not reach the vast majority of the country's rural poor. The administrative capacity or the political will to develop systems that effec-

tively provide services at the community level exists in only a few developing countries.

The consequences of population dynamics affect all nations in an increasingly interdependent world, and require increased awareness, concern, and response from both developed and developing countries. Unfortunately, population has become a highly political international issue. In the North-South debate, for example, developing country spokesmen seldom acknowledge the critical role of population dynamics in achieving their development goals, reflecting the South's view that population issues are secondary. The primary issue, in their view, is the North's refusal to accept any significant changes in the existing international economic system or the need for larger transfers of resources, technology, and jobs from developed to developing countries. This unfortunate impasse makes it difficult for either developed or developing countries to openly address their legitimate population concerns.

There are indications that developed country support for family planning programmes in developing countries may be inadequate to meet rising needs in the 1980's. Slowing economic growth, rising unemployment, escalating energy costs, and inflation in several of the major donor countries have contributed to declining levels of political support for development assistance programmes. Reduced levels of support for family planning may be one consequence of these problems, but may also reflect the concern in some donor countries that effective commitment to family planning in developing countries is too weak to justify large-scale external assistance.

There are, of course, important constraints to increased government commitment to family planning in both developed and developing countries, often in the form of organised political, religious, or ethnic opposition. Overcoming such opposition requires effective and committed national leadership capable of transcending the tendency of political leaders everywhere to trade off future benefits against short-term political interests. A commitment to resolving population issues requires a long-term view of social gain with few immediate political rewards. Yet there are many leaders who have made such a commitment and vigorous family planning programmes can be found in countries that represent the full spectrum of political, religious, ideological, ethnic and cultural variation.

At the national level, there are a number of possible approaches to increase and broaden effective commitment to family planning efforts. The experience of many family planning associations and voluntary organisations shows that one of the most effective strategies to secure the commitment of national decision-makers lies in building public support for specific causes and activities. Programmes which have their roots firmly established in the communities they serve have the best chance to generate such support.

Official commitment to family planning can also be strengthened by efforts to increase knowledge and understanding among policy-makers, planners and opinion leaders of the relationship between population and various aspects of development. Collaborative efforts involving national research institutions and policy-making bodies, combined with more active media efforts, can make a substantial contribution to better understanding of these relationships and the role of family planning.

Practical experience in incorporating population into development planning and programmes is still not sufficiently strong or widespread, even though the principle of integrating population with development is now widely accepted. The development of effective strategies clearly depends on a closer link between population planners and those working in other sectors of development. Increased opportunities for training in integrated development planning and programming are needed to help build the necessary capacity for strategy development.

Successful approaches to strengthening national commitment to family planning will undoubtedly differ in specific contexts. Whatever the approach, increased commitment of national organisational, political, and financial resources will be necessary in order to expand coverage and improve programme performance. Increased national commitment will also be necessary to enable some donor countries to justify increased--and perhaps even current--levels of support for family planning in the 1980's.

RESOURCES FOR THE 1980's: WHERE WILL THEY COME FROM?

Achieving national self-sufficiency in support of family planning efforts will be a major task in the decade ahead. Precise estimates of resources specifically allocated to family planning by developing country governments are difficult to obtain.

Several Asian governments have made substantial increases in their support for national family planning programmes in recent years; in most other cases resources specifically allocated to family planning have been relatively small. In part this reflects the reality of limited government resources, but it also indicates either that family planning services do not receive high priority or that the availability of large-scale external funding may itself inhibit the allocation of local resources for these purposes.

In all countries there are always many competing demands on limited financial resources, but only a few ways to finance investments in health, education and other social programmes. The situation is made even more difficult by the slowdown of economic growth in many developing countries and the rapid rate of increase in the cost of essential imports. Aside from external grants and loans, governments can increase tax revenues, reallocate existing revenues, or help mobilise non-governmental resources at the individual, community, and national levels. Most developing countries have only limited ability to significantly increase tax revenues or to make major reallocations of existing revenues over the short-term future. A much greater proportion than before of the needed resources will therefore have to come from local communities, private sources, and contraceptive users themselves.

National programmes will have to seek, more imaginatively and more enthusiastically, effective strategies to identify and use locally available resources. An essential component of this process will be the better use of human resources, especially at the community level. As noted previously, health and community development workers, traditional medical practitioners and birth attendants are examples of human resources that can be used more effectively. Non-governmental organisations working in many sectors constitute an important resource for programme implementation and the delivery of services at the community and national levels.

Incorporating family planning services into existing development programmes may contribute to more effective use of available resources by reducing operating costs and the need for investments in separate infrastructures. Identification, refinement, and implementation of integrated, cost-effective approaches are critical needs. Better coordination among various government departments and private organisations engaged in delivering public

services would also help prevent wasteful duplication of effort and expenditure.

Increasing national self-sufficiency requires that family planning consumers bear a greater share of the cost of contraceptive services and supplies. There are several ways in which this can be done. Family planning users who obtain services and supplies from public sector programmes may be able to support a larger share of programme costs through payment of fees, as has been demonstrated in several national programmes. Governments can encourage greater reliance on private sector marketing and distribution of contraceptives. More attention can be given to establishing self-financing voluntary health insurance schemes at the community level which include provision of family planning services and information. Other forms of community self-help projects may also be able to incorporate family planning among their objectives and activities.

Until recently, developing countries could only turn to a small number of developed countries for technical and financial assistance for family planning. A great deal of valuable experience and technical expertise in designing and implementing family planning programmes at the community and national levels now exists in developing countries. Of particular importance is the experience gained in developing low-cost or community-financed programmes. Greater reliance on technical cooperation among developing countries, at both the official and non-governmental levels, can help disseminate this experience more broadly. Similarly, there is now much greater opportunity and need for increased economic cooperation among developing countries, particularly as the oil-exporting countries increase their own development assistance programmes.

During the past decade, international assistance for population and family planning programmes in developing countries more than tripled, from an estimated \$125 million in 1970 to almost \$400 million in 1978. But there is growing concern at the start of the 1980's about the level of future support for population activities from at least several of the key international donors. The British government, for example, has announced its intention to reduce the level of funding specifically earmarked for population assistance. The prospects for continued high levels of population assistance from the United States are uncertain. Total contributions to the UNFPA for at least the next three to four years are likely to be considerably lower than projected increases in demand for

assistance from the Fund. As the Brandt Commission (The Independent Commission on International Development Issues) observed, it is ironic that international support for population activities may be weakening at just the moment when developing country demands for such assistance are increasing to unprecedented levels.

External economic assistance for family planning is of critical importance in at least four areas: meeting the foreign exchange requirements of providing commodities and supplies; research and development of new or improved contraceptive methods; training of programme personnel, particularly in clinical aspects of contraceptive use; and financing experimental and innovative approaches to service delivery. In many poor developing countries, family planning programmes would be severely weakened if external support were significantly reduced. And in all developing countries, additional resources are needed from both national and external sources if projected increases in the demand for family planning services during the 1980's are to be met.

The need for additional financial support for family planning from the international donor community is clearly stated in several major reports on global economic prospects in the years immediately ahead, including the report of the Brandt Commission, the Global 2000 Report to the President of the United States, and the World Bank's 1980 World Development Report. The International Conference of Parliamentarians on Population and Development, meeting in Colombo in 1979, called on governments to double their international population assistance by 1984. In spite of the current poor economic situation in many developed countries, it is to be hoped that these urgent calls will be heeded.

In a period of global economic disorder and uncertainty, there is a tendency to cut back on support for social and human development programmes domestically and internationally, but as the 1980 World Development Report argues so eloquently, such cutbacks now can have disastrous effects later.

The level of human development at one time is strongly influenced by its level decades earlier. Thus, human development is not something that can be deferred: what is done now--or not done--will have an influence for a long time to come. When austerity programs are necessary (as will be the case for a number of countries over the next few years), attention should be given to the

need for investment in the human development of the next generation. When economic difficulties originating in the workings of the world economy or economic mismanagement cause cutbacks in human development programs, children pay heavily--in loss of future income or health, and in some cases with their lives.

Support for human development programmes such as education, health, and family planning is an important investment in the future, but effective programmes take time to develop and require persistence in support and dedication in implementation. Family planning programmes throughout the world made impressive progress during the 1970's, and even more is needed, wanted and possible in the 1980's.

1987 2000
2000 2000

Annex to the Background Document:

**Review of the Current Status
of Family Planning**

This document was published prior to the Conference and provided additional reference material.

This document was written by Stephen L. Isaacs with contributions from Barnett Baron, Donald Lauro, Deborah Maine, Dorothy Nortman, S. Bruce Schearer, and Walter Watson and with the research assistance of John Bongaarts, Leslie Corsa, Martin Gorosh, and William van Wie.

I. INTRODUCTION

As an international movement, family planning is comparatively new. Although courageous pioneers fought in this and the preceding century for the right of people to control their fertility, it was not until 1952 that the international outlines of the movement took definite shape. In that year, India announced the world's first population policy and the separate efforts of 15 countries were consolidated into a single international federation. In the 1960's and 1970's, with the development of more effective contraceptive methods, it became possible to think of making family planning available to all people desiring it.

During the past two decades, the family planning field has shown remarkable development. By the 1980's, most of the world's governments, containing the vast majority of the human race, had established policies favourable towards family planning, and either offered family planning as part of their national health services or supported a private family planning association. Innovative family planning programmes, particularly those functioning at the community level, had been tried and shown to work. Contraceptive prevalence had increased and fertility fallen quite dramatically in a number of developing countries.

The growth and development of the family planning movement should not obscure the many difficulties which exist. Services remain inadequate in many countries, particularly in rural communities and urban slum areas, and are non-existent in some others. Funding of programmes is insufficient to meet rising demand for services in many countries, and family planning is frequently accorded a low budgetary priority. Better contraceptive methods are needed, but research towards this is underfunded. Religious and other groups have mounted organised opposition to some methods of contraception. The role of abortion in family planning remains highly controversial. Some radical political movements reject family planning as a palliative, while the North-South debate over economic development and the distribution of resources threatens to sidetrack international support. These difficulties, and others, are examined in the Background Document.

In order to make sure that the information presented is the latest available and expresses the consensus of authorities in the field, extensive

literature reviews were conducted and a great many sources were consulted. As is inevitable, however, in any such examination of an entire field, some of the inherent complexity has been sacrificed in the interest of breadth and clarity. Although the Annex does not contain footnotes, all the information presented in it is supported by published literature. An abbreviated bibliography of some of the key works consulted has been provided as the final section of the document.

II. NATIONAL POLICIES, LAWS AND REGULATIONS

GOVERNMENTAL ATTITUDES TOWARDS FERTILITY AND FAMILY PLANNING

The single most important reference point for analysis of population policy in the 1970's was the World Population Conference of 1974. Although the two weeks of the conference witnessed a tension between family planning advocates and development partisans, the consensus that emerged--that family planning is an integral part of the socio-economic development process--has been widely accepted today. One section of the World Population Plan of Action required the United Nations to monitor implementation of the Plan of Action. Accordingly, the United Nations has sent a number of Inquiries to governments requesting information about their perceptions of population and development.

In July 1978, the United Nations conducted its Fourth Inquiry among Governments on Population and Development to ascertain the current state of official government perceptions and policies related to population. Data were collected for 116 developing countries and 42 developed countries. The results constitute an overview of the policy context in which family planning programmes operate today.

A high degree of consensus exists with regard to mortality and spatial distribution policies. There was considerably more diversity among governments with respect to fertility levels and policies to deal with them. Of the developing countries that responded, 51 reported their level of fertility was too high, 53 reported their fertility level to be satisfactory, while only 12 considered it to be too low. Fifty-seven percent of the Asian countries replied that their fertility levels were too high

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and therefore unsatisfactory, a view shared at the official level by 18 percent of the Latin American countries, 38 percent of the African countries, and 17 percent of the Middle Eastern countries. Among developed countries the perception differed considerably; of the 42 countries that responded, 10 perceived their fertility to be too low, 31 perceived it to be satisfactory, and only one found it to be too high. Table 1 presents a summary of governmental positions on current levels of fertility.

TABLE 1. Government Views on Current Levels of Fertility (by United Nations regional classifications) (number of governments)

	Rate Unsatisfactory (too low)	Rate Satisfactory	Rate Unsatisfactory (too high)	Total
Africa	6	25	19	50
West Asia	1	9	2	12
Latin America	3	11	13	27
Europe	10	28	1	39
East Asia	2	11	17	30
More developed regions	10	31	1	42
Less developed regions	12	53	51	116
Total	22	84	52	158

SOURCE: United Nations, *World Population Trends and Policies, 1979 Monitoring Report*, Volume II, Table 17, page 29.

NATIONAL FAMILY PLANNING POLICIES

Governmental perceptions of fertility bear a relationship to, but do not coincide perfectly with, governmental policies towards family planning. On a global level, by 1980 almost the entire developed world and the vast majority of developing countries, containing more than 90 percent of the developing world's population, were supporting family planning--either by means of a government programme or by support of non-governmental family planning activities. Of the 158 countries responding to the United Nations Fourth Inquiry, 118 supported family planning: 98 through government programmes and 20 through programmes receiving indirect government support. Table 2 presents a summary of government policies concerning access to modern methods of birth control.

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TABLE 2. Government Policies Concerning Access to Modern Methods of Birth Control (number of governments)

	Access limited	Access not limited			Total
		Not Supported by Government	Indirectly Supported by Government	Directly Supported by Government	
Africa	5	12	10	23	50
West Asia	1	5	2	4	12
Latin America	1	4	1	21	27
Europe	4	4	6	25	39
East Asia	2	2	1	25	30
More developed regions	5	4	7	26	42
Less developed regions	8	23	13	75	116
Total	13	27	20	98	158

SOURCE: United Nations, *World Population Trends and Policies, 1979* Monitoring Report, Volume II, Table 19, page 30.

As the table indicates, approximately 80 percent of the developed countries responding to the Fourth Inquiry (33 out of 42) and about 73 percent of the developing countries (85 out of 116) had policies which supported access to modern means of contraception. Of the developed countries or territories responding to the Fourth Inquiry, only Argentina, Greece, the Holy See, Ireland, Liechtenstein, Malta, San Marino, Spain and Uruguay did not provide support to family planning. In developing countries, both the existence of, and justification for, government policies towards family planning vary considerably by region. These are reviewed below.

1. Asia. In the 1950's and 1960's many Asian countries recognised the deleterious effect of rapid population growth on socio-economic development and adopted policies to reduce their population growth rates. These included China, India, Indonesia, Iran, the Republic of Korea, Malaysia, Nepal, Pakistan, Singapore, Sri Lanka, Taiwan and Turkey. To date 18 Asian countries, accounting for 94 percent of the population of the region, have adopted official policies to reduce population growth rates. Many governments of the region have established active family planning programmes and have taken policy steps beyond family planning such as providing incentives for sterilisation acceptors (Bangladesh, India and Sri Lanka), rewarding families with fewer children by tax incentives (Indonesia, the Philippines and Thailand), providing economic incen-

tives and disincentives to have smaller families (China and Singapore), and mobilising peer pressure (China). The only countries in the region which do not support family planning are Burma, Kampuchea, the Democratic People's Republic of Korea, Laos and Mongolia.

2. Latin America and the Caribbean. In 1965 the maternal and child health services of only five Latin American and Caribbean countries offered family planning services. Five years later, this list had increased to 17 countries. By 1980 all Latin American and Caribbean countries, with the exception of Argentina, Bolivia, Guyana, Surinam and Uruguay, were offering family planning as part of the government's health services, justified principally on the grounds of promoting maternal and child health. A number of countries, including Barbados, Colombia, the Dominican Republic, El Salvador, Jamaica, Mexico, Trinidad and Tobago, have established targets for reducing population growth rates as part of their development plans.

3. Sub-Saharan Africa. Mortality, especially infant mortality, is very high in sub-Saharan Africa. In most countries there is little concern over population pressures or availability of land, and in a number of west and central African countries, infertility is considered a major problem. For these reasons, family planning has received less support in sub-Saharan Africa than in any other region. Fifteen countries, primarily in francophone Africa, have adopted policies which either limit access to modern means of contraception or are not supportive of it. The remainder of sub-Saharan Africa supports family planning primarily for reasons of improving maternal and child health and, in a few cases, to reduce population growth rates.

4. Middle East and North Africa. A number of Middle Eastern and North African countries, including Egypt, Morocco and Tunisia, have supported family planning to facilitate development by reducing population growth rates since the mid 1960's. Other governments, such as those of Algeria, Jordan and Syria, promote family planning on grounds of its benefits for maternal and child health. Most of the oil producing states, including Iraq, Kuwait, Libya,

the United Arab Emirates, Saudi Arabia and Qatar, do not support family planning.

NATIONAL LAWS AND REGULATIONS

Although laws and regulations of many countries constitute a barrier to fertility regulation services, the past decade has been marked by decreased restrictions on the distribution of contraceptives, particularly the distribution of oral contraceptives by non-physicians, and greater access to voluntary sterilisation through either changes in the relevant laws or their interpretation. Additionally, the abortion laws of many countries have been liberalised. In general, the laws regulating contraception, sterilisation, and abortion follow the patterns of national family planning policies discussed above. Thus, the laws governing fertility regulation tend to be restrictive throughout most of Africa, Latin America and the Middle East and are more permissive in Asia and the developed world.

1. Fertility regulation as a human right. The right of people to have the number and spacing of children they desire has been considered a human right and has been so established in a number of United Nations resolutions dating from the International Conference on Human Rights held in Teheran in 1968 and continuing through the declaration of the International Women's Year Conference held in Mexico in 1975. Currently five countries have incorporated this right in national constitutions: China, Ecuador (which added a provision in 1980), Mexico, Portugal and Yugoslavia.

2. Reversible contraception. Information about, and provision of, contraceptives can be affected by laws and regulations restricting their import and export, manufacture, advertising, mailing and distribution. Legal and regulatory obstacles to family planning exist to varying degrees in most nations. Perhaps the most critical legal/regulatory issues are those which affect the distribution of contraceptives, particularly: what kinds of personnel should be permitted to distribute contraceptives? Should physicians, nurses, midwives, community agents or others be permitted to distribute contraceptives? What kinds of contraceptives should each category of personnel be allowed to deliver?

Most countries legally require that oral contraceptives be prescribed by a physician and distributed through pharmacies; however, some countries permit trained health workers and auxiliaries to distribute the pill. Countries which do not require a prescription or which allow pills to be distributed in facilities other than pharmacies include China, Fiji, Mexico, Morocco, the Philippines and Thailand. Whatever the written laws may be, they are often not implemented in practice. Thus, even when laws are restrictive, as in most of Latin America, sub-Saharan Africa, and parts of Asia, oral contraceptives are often available without prescription from pharmacies, and community-based distribution programmes recruit and train non-physicians to distribute them.

Insertion of intrauterine devices, although rarely treated explicitly by law or regulation, is usually considered an element of medical practice and reserved for physicians. Although fewer than 20 countries currently permit non-physicians to insert IUD's, trained nurses, midwives or auxiliaries have proven competent to carry out the procedure effectively and the trend is to permit them to do it. During the last decade, Chile, Korea, and the Philippines eased their regulations so that properly-trained health and auxiliary personnel, as well as physicians, could insert IUD's.

3. Sterilisation. Since sterilisation is a popular but generally irreversible procedure, legal problems exist both in assuring access to people who genuinely want sterilisation and, at the same time, in preventing abuse and coercion, particularly where minorities, minors and the mentally retarded are concerned. In addition, religious and ethical concerns about a surgical operation resulting in permanent sterility have led some governments to prohibit the procedure altogether or, where it is allowed, to restrict its availability.

Twenty-one countries have provisions in their laws explicitly making sterilisation legal, while in another 60 countries, voluntary sterilisation is not specifically prohibited and judicial decisions, health ministry regulations, or other administrative actions indicate that it would not be considered a criminal act. In another 19 countries, many of them former French colonies, sterilisation is not specifically mentioned but would probably be considered a criminal offence. In 38 countries, no special provision covering voluntary sterilisation exists in

the criminal code and the legal status of the procedure is unclear. Only Burma, Peru, Somalia, Spain and Turkey have laws or regulations prohibiting sterilisation as a method of family planning.

Even where voluntary sterilisation is considered legal, laws and regulations often prescribe certain restrictions on the performance of the operation. Many of these are designed to assure that the informed consent of the person is obtained. Some of the common requirements are a waiting period, minimum age requirements, spousal or parental consent, and a specified number of living children.

Sterilisation of the mentally retarded and minors involves special legal problems since people in these categories are considered, by definition, incapable of understanding the nature and consequences of the procedure and therefore cannot give their informed consent. Many countries either prohibit the sterilisation of the mentally retarded or minors altogether or permit it only under specified conditions and upon receipt of the approval of a judicial or administrative body.

4. **Abortion.** Abortion raises ethical and religious questions of the most fundamental nature. Because of the strong objections to abortion, many governments have imposed severe restrictions on its availability and even where abortion is permitted, it is frequently under attack. Throughout almost all of Africa and Latin America, and some parts of Asia, abortion is either prohibited completely or permitted only to save the life or physical health of the pregnant woman. In almost the entire developed world and in many countries of Asia, including China and India, abortion is available on broader grounds, such as protecting the health, including the mental health of the woman, avoiding unfortunate social or economic consequences, preventing the birth of a deformed child, or simply, on request.

The recent trend in abortion law, at least in the developed world and Asia, has been towards liberalisation. Of the jurisdictions which have modified their abortion laws since 1976, 40 have extended the grounds for abortion while six, four of them Eastern European countries attempting to increase population growth rates, have restricted legal access to abortion.

However, even where the laws as written are comparatively permissive, they often are not well implemented because of bureaucratic procedures, misunderstanding, or obstructions, and services are not

widely available. On the other hand, the relatively restrictive abortion laws prevalent throughout Latin America are rarely strictly enforced; clandestine abortion is still widespread and is considered a significant cause of maternal morbidity and mortality; few practitioners are prosecuted and the treatment of incomplete abortions continues to drain the resources of many hospitals.

III. FAMILY PLANNING PROGRAMMES AND SERVICES

PROVIDERS OF FAMILY PLANNING SERVICES

Family planning services can be provided by (1) the government, through its ministry of health, the social security system, or some other public mechanism, (2) non-governmental organisations, and (3) the private commercial sector.

Government family planning programmes have usually come under the aegis of ministries of health, using public sector funds, facilities, and health workers to deliver services. In some countries, particularly in Latin America, the quasi-governmental social security system provides information and services to an insured population. In many developing countries, however, the villages, where a large proportion of the population resides, are beyond the effective reach of the governmental health system, which frequently has retained a clinical orientation and has been weak on outreach. Some governments-- such as those of Bangladesh, China, Egypt, Indonesia, Mexico and Thailand--have instituted large-scale programmes to serve inhabitants of rural communities and/or urban slums.

Historically, the associations affiliated with the IPPF have been the pioneers of family planning, offering information and services before governments were prepared to accept that role or were able to develop the health infrastructure necessary to provide services on a wide scale. Currently, 95 such associations exist, playing a variety of roles depending on local needs and conditions.

Throughout the world, many hundreds of organisations play active roles in providing family planning information and services. These include women's clubs, labour unions, agricultural cooperatives, religious groups, and rural development groups. Some examples are the Concerned Women for Family

Planning in Bangladesh, the Federation of Agricultural Co-operatives in Guatemala, the Singapore Industrial Workers Labour Organisation, and the Ethiopian Women's Association.

Although accurate figures are not available for most countries, the commercial sector (particularly pharmacies) is believed to play a significant role in supplying contraceptives in countries with market economies. The range is considerable, however: in the Dominican Republic and El Salvador, the private sector accounts for more than two-thirds of the supply of contraceptives; in Korea, Costa Rica, Taiwan and Malaysia it accounts for 50 percent; and in Singapore, 20 percent. A recent survey in Mexico revealed that slightly more than half of the pill users obtained their supplies through pharmacies and even higher percentages obtained condoms, injectables and suppositories through the same channel. (Table 6 shows the role of the private and public sectors in furnishing contraception.)

FAMILY PLANNING SERVICE DELIVERY

In recent years, as the concepts of community health and primary health care have gained greater acceptance and as shortcomings in clinic-based programmes have become manifest, there has been an increasing tendency to extend family planning programmes into smaller rural communities and urban slum areas. New approaches have been utilised by government and the private sector alike. These include contraceptive distribution by trained health and auxiliary personnel (such as midwives, auxiliary nurses, fieldworkers, and community agents), postpartum programmes, greater use of commercial channels, integrated primary health care and development programmes, and closer association with groups such as agricultural co-operatives and labour unions.

The willingness to move from the traditional, clinic-based, medically-oriented health care system to more innovative approaches has been one of the noteworthy achievements of the family planning field over the past decade, an innovation upon which other community development programmes can build. The major systems of providing family planning services are reviewed below.

1. Hospitals, clinics and health posts. Services offered by organised family planning programmes have traditionally been provided in hospitals or clinics.

The distinction between hospital-based and clinic-based family planning services is more a matter of degree than kind since both are usually staffed by doctors and nurses. The range and quality of services available in hospitals and clinics varies considerably from country to country and within countries. In some instances the service provided is limited to counselling about contraception or to the provision of only one or two contraceptive methods. At the other extreme, some hospital programmes include, along with appropriate counselling, a full complement of contraceptive, sterilisation, abortion, and infertility services. Postpartum family planning information and services are now offered by many of the world's larger hospitals and an increasing number of smaller hospitals as well.

The experiences of health ministries in many developing nations have been similar in that family planning was initiated in the largest and best equipped hospitals, frequently university teaching hospitals, and clinics. As the programme took hold, it was expanded to hospitals and clinics at the regional level. Because such services are still not accessible or acceptable to most people, it often has been necessary to take the additional step of introducing family planning into the localised facilities of the health system infrastructure, usually through establishment of rural health centres or posts. Construction of rural health centres and posts has boomed within the last five years. For example, in Mexico 2,000 new rural health clinics, staffed by doctors providing one year of social service, have been built over the past two years.

2. Private physicians. Family planning is often provided as one of the number of services that physicians offer in their own clinics. In the Republic of Korea and Taiwan, for example, where private doctors are accessible to large proportions of the population, they are paid on a fee-for-service basis to provide most of the sterilisations and IUD insertions in the government programmes. However, in most developing countries, both the price structure and the urban concentration of physicians have tended to result in a highly-centralised delivery system. New efforts are being made to involve private practitioners in the delivery of family planning services in several countries including Colombia and Bangladesh, and in many countries recent medical school graduates provide six

months or a year of social service in rural or urban slum health posts or centres.

3. Mobile units. A superficially appealing way to extend family planning services has been to equip buses, vans, trailers, and even boats as mobile family planning clinics. Programmes of this kind have been undertaken in Thailand and Mexico, among other countries. However, mobile units have produced only modest results. For one thing, shortages of medical personnel are not satisfactorily relieved by using mobile clinics and follow-up care is sometimes erratic. In addition, mobile units are costly to equip and maintain, particularly in periods of rising fuel costs.

4. Special campaigns. Special campaigns to attract family planning acceptors are most closely associated with the programmes of Asia. The sterilisation camps which India initiated more than ten years ago are one example. The camp concept involved undertaking a maximum effort for a short period in a given locale. Medical personnel, equipment and facilities were assembled, mass media appeals made, and support from local leaders mobilised. Frequently incentives, both cash and in-kind, were offered. In a number of instances, there was a dramatic increase in the number of sterilisation acceptors. However, the ethics, and in some cases the effectiveness of the camps and mass sterilisation drives have been questioned, and the camp concept has not been tried on a systematic basis outside of the sub-continent.

Variants of the campaign approach have been tried within the context of several existing family planning programmes. Indonesia has conducted special drives during a designated "Family Planning Month." In the Republic of Korea, efforts to reach annual acceptor targets have been intensified during certain seasons. Evaluations of these approaches have shown them to be successful in the countries named.

5. Services for particular groups. Intensive efforts have been made to meet the needs of particular groups in need of services such as factory workers in El Salvador, India and the Republic of Korea, members of religious groups, e.g., the Iglesia ni Cristo in the Philippines, and adoles-

cents in Guatemala, Mexico and Panama. Frequently, these programmes combine family planning with other services, such as health, agriculture, or community development.

6. Commercial retail sales. While pharmacies and other retail outlets have sold contraceptives for a long time and are considered a major source of contraceptive supplies in many countries, it is only recently that any substantial attention has been directed to developing programmes that use public funds to employ the market system as a channel for distributing contraceptives. Since retail outlets such as pharmacies and small general stores are widely dispersed and utilised in most countries, commercial distribution programmes offer the promise that more people will have easier access to contraceptive methods such as condoms, spermicides and pills.

Currently, projects in more than 30 countries, supported and financed by both governments and non-governmental organisations, utilise retail outlets such as pharmacies and small shops to distribute contraceptives bearing such names as "Preethe" and "Panther" for condoms and "Pearl" for oral contraceptives. Countries with commercial retail sales programmes are listed in Table 3.

TABLE 3. Countries Having Commercial Retail Sales Programmes, 1980

Asia	Middle East/ North Africa	Sub-Saharan Africa	Latin America and the Caribbean
Bangladesh	Egypt	Ghana	Antigua
Fiji	Morocco	Kenya	Barbados
Hong Kong	Tunisia	Mauritius	Colombia
India			Costa Rica
Indonesia			Guatemala
Korea			Haiti
Malaysia			Honduras
Nepal			Jamaica
Pakistan			Mexico
Philippines			Panama
Sri Lanka			St. Kitts/Nevis
Thailand			St. Lucia
			St. Vincent
			Uruguay

SOURCE: Walter Watson, Donald Lauro, and Nuray Fincancioglu.

The experience to date of these programmes suggests that, by and large, they have succeeded in improving contraceptive availability and increasing

the sale of contraceptive products. For example, in India, condom sales grew from less than 25 million in the late 1960's to more than 160 million in 1978-79, of which 118 million were "Nirodh," the brand used in the commercial sales campaign. In Sri Lanka, condom sales increased from about 500,000 in 1972 to nearly 6 million in 1978, and Bangladesh, Colombia, Jamaica and Thailand have all seen large increases in condom and oral contraceptive sales since projects began in 1973-75. Despite these sales, few of the programmes have been able to become self-sustaining without need for public subsidies. This remains a major limitation of these programmes.

7. Integration of family planning with primary health care and development programmes. An increasingly important way of providing family planning services is to integrate them with primary health care and other development activities, particularly at the village level. This accords with the declaration of Alma Ata, which emphasised the importance of primary health care, including family planning, and is in keeping with the priorities of the World Health Organisation and many national governments. In many cases village-level workers have been trained to provide a range of curative and preventive health services including nutrition, oral rehydration therapy, antiparasite treatment, environmental sanitation, and, of course, family planning. This approach has been utilised in countries as diverse as Bangladesh, Egypt, Ghana, Haiti, India, Nigeria, the Philippines, and the Sudan; as one example, the Mexican national family planning programme has trained more than 12,000 community workers since 1976. These agents, living in rural areas throughout the country, provide a number of basic health services to their neighbours, including treatments for parasites and worms, diarrhea, and infection as well as distributing a variety of contraceptives.

Family planning can be one element integrated with primary health care or development activities, as in the countries mentioned above. Conversely, primary health and village development can be added to successful family planning projects. The community-based family planning programmes in both Indonesia and Thailand have evolved in just this direction. Attempts are underway in both countries to provide additional health and development activities through channels originally established by the

family planning CBD projects. In Indonesia a comprehensive programme including nutrition, primary health care, and income generating activities such as home gardening and village food co-operatives is being developed to operate through the system originally established for family planning. In many instances, the initiative for participation in these broader health and development activities has arisen from the communities themselves. In Thailand, some of the 16,000 villages which are part of the Community-Based Family Planning Services network are initiating latrine building, water tank construction, pig raising, home gardens and conversion of animal wastes into bio-gas.

8. Using health auxiliaries at the village level. Various categories of health auxiliaries, including auxiliary nurses, midwives, paramedics, and sanitarians, have received supplementary training in family planning. Perhaps the most widely publicised village-level health auxiliary is the so-called "barefoot doctor" of China. The services provided by health auxiliaries range from giving motivational talks within the context of their usual work to inserting IUDs or dispensing pills. In the Sudan, for example, a pilot project is underway that utilises government-trained village midwives to provide maternal-child health and family planning (MCH/FP) services at the village level. An interesting feature of this project is that it begins with an intensive period of household canvassing during which various health activities such as oral rehydration therapy and contraception for birth spacing are introduced. Subsequently, midwives become the repositories of any supplies that are needed and undertake MCH/FP activities as a more routine part of serving their home communities.

In many countries, such as Indonesia, Malaysia, Nigeria, Sri Lanka and Thailand, traditional practitioners have been trained to provide family planning information and services. Traditional practitioners have been most widely used in Asia and have been utilised to a lesser, but growing, extent in Latin America.

9. Community-based distribution systems. Community-based distribution (CBD) systems have been one of the effective ways of bringing family planning services to people in rural villages and urban slums. Utilising trained health personnel or commu-

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nity workers to provide family planning services, CBD projects have been initiated in nearly 40 developing countries. These are listed in Table 4.

TABLE 4. Countries Having Community-Based Distribution Programmes, 1980

Asia	Middle East/ North Africa	Sub-Saharan Africa	Latin America and the Caribbean
Bangladesh	Egypt	Ghana	Brazil
China	Lebanon	Liberia	Colombia
Hong Kong	Morocco	Nigeria	Dominican Republic
India	Sudan		Ecuador
Indonesia	Tunisia		El Salvador
Korea			Grenada
Malaysia			Guatemala
Nepal			Haiti
Papua New Guinea			Honduras
Pakistan			Jamaica
Philippines			Mexico
Sri Lanka			Nicaragua
Taiwan			Panama
Thailand			St. Lucia
			St. Vincent
			Trinidad & Tobago

SOURCE: Walter Watson, Donald Lauro, and Nuray Fincancioglu.

Most CBD projects serve small populations; however, large-scale projects exist in Bangladesh, Brazil, Colombia, Egypt, Korea, Indonesia, Mexico, the Philippines and Thailand. Although virtually all CBD programmes utilise people from the community to provide family planning services, considerable diversity exists among programmes regarding qualifications of people selected as agents, the amount of training they receive, the types of services they provide, and the ways in which they are supervised, supplied and compensated.

The decision as to how a particular programme should be structured and who should be the primary agent depends largely on the particular socio-economic and cultural context in which a programme is to operate. In Thailand, for example, CBD efforts have been channelled through village volunteers who act independently to sell pills at a nominal fee to villagers who wish to purchase them. Although they are visited monthly by programme supervisors, for the most part the volunteers are left on their own. In contrast, in Indonesia, where community groups are an important feature of village life, CBD programmes have been structured differently. In Java, women's clubs have become an important feature of community-based efforts; in Bali the

Banjar system which organises village males into regular meetings has been utilised as a support mechanism for family planning acceptance. In Brazil, BEMFAM, the private family planning association, working with state governments, utilises personnel within the state health system as distribution agents to provide pills free of charge, while in Guatemala members of agricultural co-operatives have been recruited to sell contraceptives to their fellow co-operative members and to local residents who are not part of the co-operative.

A variation of CBD programmes, "household distribution" (whereby every household in a community is visited and offered family planning supplies) has been undertaken in Colombia, Morocco, Tunisia, Egypt and Haiti, among other countries. Evaluations have indicated that household distribution has led to short-term increases in contraceptive prevalence attributable to the door-to-door canvassing. Long-term success appears to depend on accessibility to a system of resupply, which is usually achieved by using the home or shop of the local community agent as a supply depot.

Distribution of oral contraceptives has been the mainstay of most CBD programmes although other methods and referrals to clinics for IUD insertion, for sterilisation, or for provision of simple health services have sometimes also been done. In some countries, there appears to be an evolution from CBD programmes that are categorically family planning to those that integrate family planning into other health or development activities or that integrate the latter into family planning programmes.

Analyses based on the limited evaluation data available indicate that community distribution programmes have been an effective and, in some instances, the only feasible way of serving rural and urban slum residents. Acceptance rates, continuance rates, and prevalence increases have been comparable to, if not higher than, those of many clinical programmes, and the CBD projects have achieved these in areas generally served by clinics.

FAMILY PLANNING COMMUNICATION

Communication is an integral element of family planning programmes. It may be viewed in terms of the audience served (e.g., out-of-school youth, government leaders, potential acceptors), the media of communication used (radio, newspaper, fieldworkers),

or the purpose of the communication (sex education, information on contraceptive methods, raising consciousness). Often categorised as "information and education", communication elements of family planning programmes are used to increase awareness, influence attitudes and to assure that people's decision to adopt family planning is an informed one. To date, family planning communication has been very much an empirical field, with little solid evidence from evaluations to support claims of its supporters or detractors.

Considerable attention has been given to improving family planning communication through the mass media. Radio has become particularly important due to the widespread use of transistors, even in remote villages. It has been used to educate people, raise consciousness about population growth, and provide information on clinic locations and hours. In some countries, such as Colombia and Korea, large portions of the rural population receive regular radio broadcasts on rural development activities, including family planning. Newspapers too, are widely used for a variety of purposes, including the education of leaders. Other media utilised in family planning are film, television, telephone and mailings.

Even though communications technology has advanced considerably over the past decade, person-to-person communication still remains the backbone of family planning information and education. Throughout the world, fieldworkers, promoters, community agents, social workers, doctors, satisfied users and others have been used to discuss and promote family planning either on a one-to-one basis or in groups. Often these communicators have been supplied with supporting materials such as pamphlets, films, slides and samples. Detailed studies about which types of personnel and support are effective under different conditions and settings have not been done.

Although there have been some changes over the past few years, the teaching of population, family life or sex education in schools remains limited throughout much of the developing world. Recognition of the high percentages of young people not attending school after the primary grades has led to intensified efforts to educate out-of-school youths. Small scale projects focused on out-of-school youths belonging to labour unions, agricultural co-operatives, and other organisations have been carried out in many countries throughout the world. There is

growing concern that these educational efforts be linked with services for adolescents.

IV. FAMILY PLANNING TECHNOLOGY

The last two decades have seen a technological revolution in the methods available for controlling fertility. Most of the methods widely used today were introduced since 1960, many of them during the last decade. Depending on how they are defined, between 10 and 20 major categories of birth control technology currently exist.

A large proportion of the contraceptive drugs and devices used in family planning programmes in developing countries are manufactured by commercial enterprises in Europe, North America and Japan and supplied to these programmes by development assistance agencies. In recent years, however, this proportion has begun to decline as local manufacture, either by private companies or government-sponsored enterprises, has become more widespread.

None of the currently available methods are free of drawbacks. Both short-term side effects and long-term hazards to health are associated with hormonal contraceptives and intrauterine devices, while the barrier methods and behavioural techniques are difficult to use and often only partially effective. Sterilisation and abortion both entail surgical risks and, especially in the case of abortion, are the subject of considerable controversy because of ethical and religious objection to their use. Thus, while the revolution in family planning technology has made current family planning programmes possible, today's technology continues to be deficient in ways that lead to unwanted pregnancies, high discontinuation-of-use rates, and exposure to health hazards among people who seek to limit their fertility. Improvements in this technology remain a major goal of population research efforts, as discussed on pages 92 to 95 of the Background Document.

A brief description of the status of current methods appears below.

BEHAVIOURAL METHODS

A number of methods rely principally on behavioural action by the user rather than on drugs, devices or surgery.

1. Abstinence. Deliberate abstinence from sexual intercourse to avoid pregnancy continues to be an important means of fertility limitation in many parts of the world. Besides abstinence prior to marriage, during the postpartum period, and at other times in a couple's life together, abstinence is often practised in a systematized manner designed to avoid the fertile days of a woman's menstrual cycle. Three such techniques exist -- calendar rhythm, temperature rhythm, and symptothermal rhythm. Studies by the World Health Organisation have shown that only the strict version of temperature rhythm is highly effective. Other rhythm methods, even when practised with great discipline, care and commitment by couples, are low in efficacy.

2. Prolonged breastfeeding. Women in many countries are aware that while they continue to breast-feed a child their likelihood of conceiving another is greatly reduced. In addition to its benefits for the child, breastfeeding also delays resumption of ovulation following pregnancy. Unfortunately, this natural barrier to fertility cannot be completely relied upon: even among breastfeeding women who have not yet resumed menstruating, as many as 6 to 21 pregnancies occur per hundred women annually. Once menstruation has resumed, the antifertility action of breastfeeding becomes even less reliable.

3. Coitus interruptus and related techniques. A variety of techniques entail sexual activity without male orgasm in the woman, the most widely used of which is coitus interruptus or withdrawal. This technique is effective, costs nothing and is free of side effects to health. However, the method demands great self-control on the part of the man, and some couples find it diminishes sexual gratification, and among large populations use effectiveness is low, varying from 10 to 23 pregnancies per 100 users per year.

4. Postcoital douching. While postcoital douching can reduce the chance of conception to a limited degree, it is the least effective of the contraceptive methods currently available, with use effectiveness rates of 40-47 pregnancies per 100 users per year. It is used by only a small fraction of women practising contraception.

CONTRACEPTIVE DRUGS AND DEVICES

At least eight major categories of drugs and devices exist: oral contraceptives, minipills, injections, postcoital pills, intrauterine devices, vaginal spermicides, vaginal barriers, and condoms. Throughout the world today nearly 100 distinct forms of these contraceptive drugs and devices are in use, each employing a different chemical formulation. These 100 different products are being marketed under more than 600 brand names worldwide.

1. Hormonal methods. Twenty years have passed since the first synthetic hormones were used to block fertility in women. During this time, the types of drugs used, their dosages, and their form of administration have undergone tremendous evolution.

Oral contraceptives have become the most widely used form of reversible contraception in almost every country in the world. Theoretically, orals provide nearly perfect contraceptive effectiveness and their effectiveness in practice is extremely high (between 2 and 10 pregnancies per 100 users per year). However, oral contraceptives are associated with a number of side effects ranging from the relatively minor to increased risk of death from several causes, especially cardiovascular disease in older women and women who smoke. The extent and nature of the side effects of the pill are extremely well documented, and the incidence of serious problems is rare. Table 5 indicates the risk of death associated with various methods of contraception, including oral contraceptives, and compares these risks to childbirth.

Not yet as fully evolved or widely used are injectable forms of these synthetic hormones. Al-

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TABLE 5. Annual Number of Deaths Associated with Control of Fertility per 100,000 Nonsterile Women by Method and Age in Developed Countries

Method of Contraception	15-29 yr.	30-34 yr.	35-39 yr.	40-44 yr.
Pill:				
Nonsmokers*	1.4	2.2	4.5	7.1
Smokers*	1.6	10.8	13.4	58.9
IUD*	1.0	1.4	2.0	1.9
Traditional methods**	1.5	3.6	5.0	4.2
Traditional methods** plus abortion	0.2	0.3	0.3	0.2
Abortion only	1.5	1.7	1.9	1.2
None	6.4	13.9	20.8	22.6

*Includes 0.2 to 0.6 birth-related deaths from method failure.

**Condom, diaphragm or spermicides.

SOURCE: Allan Rosenfield, adapted from C. Tietze, "Oral and Intrauterine Contraception: A 1978 Risk Assessment," *American Journal of Obstetrics and Gynecology*, Vol. 132, No. 1, September 1978.

though monthly and three-monthly contraceptive injections offer highly effective contraception and are popular in several countries, they are associated with a high incidence of menstrual bleeding irregularities. United States authorities have prohibited the use of Depo Provera, the most common injectable, as a contraceptive based on association between the drug and cancer in beagle dogs and monkeys, among other reasons. There is no direct evidence linking cancer with injectable contraceptives in humans. Based on its analysis of the data, the World Health Organisation has recommended Depo Provera for contraceptive use worldwide.

Two other types of hormonal contraceptives, the progestin-only minipill and the postcoital pill, also exist but have proven to be of very limited usefulness. Compared to standard oral contraceptives, the minipill offers much lower effectiveness and a much higher incidence of menstrual irregularities. While the postcoital or "morning-after" pill is effective, it causes severe gastrointestinal disturbances and, if used ineffectively, can have long-term deleterious effects on offspring exposed to the drug in utero.

2. Intrauterine devices. Over a dozen types of IUDs are in use. Despite their advantage of high effectiveness, easy reversibility, continual long-term protection following a single visit to a

clinic, and freedom from drug-induced side effects, IUDs enjoy only limited popularity in most countries. One major reason is their potential to cause pelvic infections which can lead to subsequent infertility and, in rare cases, serious illness. Some new copper-releasing and progesterone-releasing IUDs cause less menstrual bleeding than other devices. Some of the new copper-releasing devices offer higher contraceptive efficacy, as well.

3. Barrier contraceptives for women. The diaphragm used with spermicidal jelly or cream has been shown to be a highly effective contraceptive if used consistently. While use of this method was quite widespread in developed countries prior to the introduction of hormonal contraceptives and IUDs and appears to be on the rise today, it remains virtually unused in most developing countries. Vaginal spermicides, which are available in the form of foam, liquefying suppositories and foaming suppositories, are exhibiting modest increases in use in both developed and developing countries, but insufficient knowledge about the effectiveness of these products, their relatively high cost, and their need to be applied during or shortly prior to coitus have restricted their acceptance.

4. Barrier contraceptives for men. The sole barrier method available for use by men is the condom, a highly effective device if used consistently, but one which has limited acceptability because it interferes with sexual intercourse. Strong promotion of this method by family planning programmes has greatly increased its use in a number of countries, however, suggesting that the potential popularity of the method may be much greater than reflected in current levels of use.

STERILISATION

Sterilisation has become an increasingly widely used method of birth control. It is important to note that although advances have been made in microsurgical techniques, both male and female sterilisation are irreversible except under highly specialised circumstances.

1. Female sterilisation. After more than a decade of experimentation with new techniques, the mini-laparotomy tubal ligation method of female sterilisation has become widely accepted as the simplest, cheapest, safest and most effective approach. Other techniques, such as laparoscopic and culdoscopic methods, hysterectomy, and the conventional laparotomy approach, remain valuable for use in specialised circumstances. If performed by qualified medical personnel, serious adverse complications to health associated with any of these surgical procedures are very rare, and their efficacy is extremely high. No long-term adverse sequelae are known to be associated with female sterilisation, which makes the method especially attractive to couples who are sure they want no more children.

2. Male sterilisation. Since the surgical procedure for male sterilisation, vasectomy, is so much simpler than the techniques for female sterilisation, both the cost and risk of surgical side effects are lower. Although complications have occurred when procedures have been carried out under inadequate medical conditions, vasectomy generally is virtually 100 percent effective and free of serious health risks. Some concerns about the possibility of adverse long-term sequelae have been raised because of findings in animal studies, but to date research investigations have not detected any long-term adverse health effects among vasectomised men.

ABORTION

Despite cultural and religious objections to abortion in many countries, women who are not able to obtain or effectively use contraceptive methods frequently resort to this technique. As a result abortion is one of the most widely practised means of fertility control throughout the world. Much of the use of abortion occurs in places where it is illegal.

1. Early abortion. The development and widespread introduction of vacuum abortion equipment, including specially designed cannulae, over the past 15 years has made early abortion (during the first three months of pregnancy) a simple, effective and safe procedure. When modern equipment and standards are

not employed, however, as often occurs when illegal abortions are being performed, the procedure is accompanied by high risks of morbidity and mortality.

2. Late abortion. Technical methods for performing abortions in the second trimester of pregnancy have also undergone major advances during the last decade, and these procedures can be carried out reliably by experienced medical personnel. These procedures, however, are more complicated than those for first trimester abortions, and they entail both greater risks to health and, frequently, greater ethical and emotional conflict for women making use of them.

V. FAMILY PLANNING PRACTICE

CONTRACEPTIVE USE AND PREVALENCE

It is estimated that throughout the world today, approximately 270 million people utilise some form of contraception, about two-thirds of them in developed countries and one-third in developing nations. About one-third have chosen sterilisation, roughly 20 percent use the pill, 15 percent the IUD, 10 percent the condom; the remaining 20 percent use other methods. In addition, an estimated 30-55 million induced abortions are performed annually throughout the world.

Considerable regional and national variations underlie this global picture. Among developing countries, the contraceptive prevalence rate is less than 20 percent. Low contraceptive use levels are found in most African and Middle Eastern countries, and in Afghanistan, Bangladesh, Bolivia, Burma, Ecuador, Haiti, Pakistan and Paraguay. At the other end of the spectrum are at least six developing countries (Costa Rica, Hong Kong, Mauritius, Panama, Singapore, and Taiwan) where contraceptive prevalence among married women of reproductive age (MWRA) is 50 percent or more.

Most significantly, there is a trend observable in almost all Latin American and Asian countries and some Middle Eastern nations towards higher contraceptive prevalence. Mexico enjoyed a three-fold increase in contraceptive prevalence from 13 percent to 40 percent of MWRA between 1973 and 1978; in

Colombia contraceptive prevalence increased from 31 percent to 46 percent in four years. The Philippines almost doubled contraceptive prevalence between 1974 and 1979, when a 37 percent prevalence rate was achieved. Indonesia, Thailand and Malaysia reached prevalence rates of 29 percent, 39 and 36 percent respectively, in 1979 compared with low levels of use a decade earlier. Table 6 contains a review of contraceptive practice in 29 developing countries.

One of the most striking developments in recent years is the increase in the popularity of sterilisation. Voluntary sterilisation has become a major method of fertility control in several developing countries as well as in the United States where, by 1976, it was chosen by almost one out of every three couples controlling their fertility. The prevalence of sterilisation in Latin American countries is particularly impressive. Recent surveys found that one-fifth of married women of reproductive age in El Salvador and Panama had chosen sterilisation; in the Dominican Republic sterilisation is the most popular method of fertility control, and in Costa Rica and Guatemala, although not dominant, it is nevertheless significant. Its popularity has also increased markedly in several Asian countries, including Thailand, Singapore and Sri Lanka. Currently, one-fifth or more of the couples of reproductive age in Hong Kong and Singapore and possibly in Fiji, Korea, and Sri Lanka as well have chosen sterilisation as their method of family planning. India has had a long history of sterilisation camps, and in China, it is estimated that 35 million people have chosen sterilisation as their means of fertility control.

Several countries witnessed dramatic increases in pill use in a very short time. For example, Malaysia went from 5 percent of married women of reproductive age in 1969 to 24 percent in 1979; Thailand from 6 percent in 1971 to 23 percent in 1979 (probably a result of Ministry of Health regulations permitting non-physicians to distribute oral contraceptives); and France, perhaps as a result of a liberalisation of its law regarding the distribution of contraceptives, increased the percentage of women using oral contraceptives from 11 percent in 1971 to 31 percent in 1978.

The number of pregnancies terminated each year by induced abortion throughout the world is not known. Estimates range from 30 million to 55 million, corresponding to abortion rates from around 40 to 70 per 1,000 women of reproductive age and to abortion ratios of 260-450 per 1,000 live births.

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TABLE 6. Percent of Married Women of Reproductive Age Practising Contraception, by Year (selection of countries reflects availability of data)

Country and Year	Both Sectors	Public Sector	Private Sector
Africa			
Egypt, 1979	17	u	u
Ghana, 1978	4	4	0
Kenya, 1975 a/	7	u	u
1979	u	7	u
Mauritius, 1975	56	52	4
1979	53	50	3
Rhodesia, 1978	14	u	u
Tunisia, 1977	20	17	3
Asia			
Bangladesh, 1977	9	u	u
Fiji, 1978	38	34	3
Hong Kong, 1975	57	29	28
1979	79	46	33
India, 1975	u	16	u
1979	u	23	u
Indonesia, 1976 a/	26	u	u
1979	29	24	5
Jordan, 1976 a/	24	u	u
Korea, 1975	34	27	7
1978	49	25	24
Malaysia, 1974 a/	33	u	u
1979	36	17	19
Pakistan, 1976 a/	5	u	u
Philippines, 1974	15	u	u
1979	37	16	21
Singapore, 1974	60	u	u
1978	71	53	18
Sri Lanka 1975 a/	30	u	u
1977	41	u	u
Taiwan, 1974	55	21	34
1979	66	35	31
Thailand, 1975 b/	37	26	11
1979 b/	53	46	7
Latin America			
Colombia, 1974	31	u	u
1978	46	u	u
Costa Rica, 1976	34	u	u
1978	64	26	38
Dominican Republic, 1976	24	13	11
1978	38	13	25
El Salvador, 1976	22	7	15
Guyana, 1975 a/	32	u	u
Mexico, 1973	13	1	12
1978	40	19	21
Panama, 1976 a/	54	u	u
Paraguay, 1977	16	8	8
Peru, 1977 a/	31	u	u

NOTE: U = unavailable.

SOURCE: Unless otherwise noted, Dorothy Nottman and Ellen Hofstatter, Population and Family Planning Programs: A Compendium of Data through 1978, 10th edition (A Population Council Factbook, N.Y., 1980) and other editions of the Nottman and Hofstatter Factbook.

a/ World Fertility Survey finding.

b/ Suwanajata et al., 1979.

CONTRACEPTIVE PREVALENCE AND FERTILITY

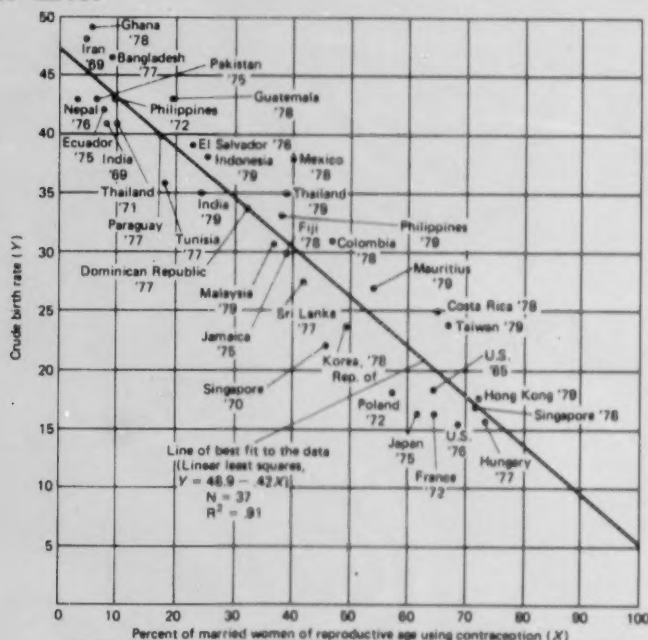
The extent to which fertility declines can be attributed to family planning or to socio-economic development has been the subject of considerable

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debate. Cases exist where fertility has declined rapidly in the presence of family planning programmes and the absence of significant development; other cases can be found where fertility has declined in the absence of family planning programmes. However, a consensus is emerging that both family planning and development contribute to fertility decline and that the two have a synergistic effect. At the very least, a strong empirical correlation has been shown to exist between levels of contraception use and fertility. Data from 32 countries show that, on the average, a 2.4 percentage point increase in contraceptive practice in a country is correlated with a 1-point decline in the country's crude birth rate. (Figure 1 shows this correlation in graph form.)

In developed countries where contraception is practised by approximately 70 percent of all repro-

FIGURE 1. Contraceptive Prevalence among Married Women of Reproductive Age and Crude Birth Rate One Year Later



Source: Dorothy Norton and Ellen Hofstetter, *Population and Family Planning Programs: A Compendium of Data through 1978*, 10th edition, p. 94. (A Population Council Factbook, New York, 1980.)

ductive-age couples (which represents virtually all couples in need of contraception), birth rates are low, averaging 16 per 1,000. In the developing world where less than 20 percent of reproductive-age couples, on the average, use contraceptives, the average birth rate is about 34 per 1,000.

Although fertility levels of developing countries are more than double those of the developed countries, fertility rates throughout much of the developing world have been declining, in some cases sharply. Chile, China, Colombia, Costa Rica, Cuba, the Dominican Republic, Egypt, India, Indonesia, Malaysia, the Philippines, the Republic of Korea, Singapore, Sri Lanka, Thailand and Turkey--to give just a partial listing--have all experienced declines of between 10 and 35 percent in the birth rate since the mid-1960's. However, a number of countries, including Bangladesh, Pakistan, Bolivia, Ecuador, and most of sub-Saharan Africa, have shown little if any fertility decline. Table 7 shows the percentage of birth rate decline in the 13 most populous developing countries.

TABLE 7. Recent Percentage Declines in Crude Birth Rates, Most Populous Countries, Three Estimates

	Estimated Population, 1980 (000's)	Crude Birth Rate Decline, 1965-75, as Reported by Mauldin (%)	Crude Birth Rate Decline, 1960/65-1970/75, UN Figures (%)	Crude Birth Rate Decline, 1960/65-1975/80, UN Figures (%)
China	976,584	24	23.1	34.6
India	672,235	16	9.6	13.6
Indonesia	142,387	13	8.5	19.2
Brazil	126,258	10	4.4	7.2
Bangladesh	88,403	3	2.6	7.5
Nigeria	86,597	1	2.9	3.9
Pakistan	82,174	1	1.4	3.1
Mexico	69,703	9	6.0	6.7
Philippines	48,170	19	3.9	11.3
Thailand	46,454	23	3.3	16.5
Turkey	45,390	16	17.3	18.5
Egypt	41,831	17	15.2	12.7
Korea, Rep. of	37,809	32	25.6	31.8

SOURCE: Nancy Birdsall, Population and Poverty in the Developing World, World Bank Staff Working Paper No. 404 (Washington, D.C., 1980), Table 3-1, p. 9.

Despite fertility declines and family planning successes, a great need for family planning services continues to exist. According to reports of the World Fertility Survey, many women in most of the developing countries participating were not using contraception and yet:

- Half of the currently married fecund women in 15 countries stated that they wanted no more children.
- In seven of eight countries where data are available, more than 25 percent of currently married women with at least one child or currently pregnant stated that their last pregnancy was unwanted.

To this should be added many millions of women who choose to terminate their pregnancies, whether abortion is legal or not.

FAMILY PLANNING, FERTILITY AND HEALTH

Although many factors contribute to maternal and infant mortality and morbidity, worldwide data have indicated that births of a higher parity, closely spaced births, and births to women near the end or at the beginning of their reproductive years carry increased risk of a number of hazards to both mother and child.

The risks to the mother of many closely spaced births include death as a result of childbirth or pregnancy, placenta previa, haemorrhage, and rupture of the uterus. Data gathered in the 1970's indicate that in many developing countries births of fifth or higher order constituted 20-45 percent of all births (compared with under 10 percent in developed countries) and births to women aged 35 or over comprised 15-25 percent of the total (compared with under 10 percent in developed countries). Additionally, the proportion of first births to adolescents is very high in most developing countries. A redistribution of pregnancies to more favourable parities and maternal ages would reduce the number of high-risk pregnancies and contribute to improved maternal health, particularly in developing countries.

Parity and the spacing of pregnancies also affect the health of infants and children. Young women run greater risks of delivering babies of low birth weight, thus increasing the risk of neonatal mortality. Women of high parity or in their late 30's or 40's run increased risks of miscarriage, still births, and infant death. While most of the data on this phenomenon come from developed countries such as the United States and United Kingdom, studies in developing areas have confirmed that this pattern holds true under a wide variety of conditions. Investigations in Latin America, for example, have demonstrated the importance of parity,

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spacing, and maternal age on the survival and health of infants and children.

VI. FINANCIAL SUPPORT OF FAMILY PLANNING

NATIONAL BUDGETS FOR FAMILY PLANNING

Although information on funds allocated to or expended by national family planning programmes is imprecise, it is possible to make some estimate based on responses of programme administrators from 24 developing countries to a Population Council questionnaire. The most recent replies are summarised in Table 8 and are provided in more detail in Figure 2.

The table and figure include funds from all sources, including national governments, international assistance, and client fees. The median annual per capita expenditure for the 24 countries was 36 cents. In some countries, e.g., Ghana, India, the Republic of Korea, Malaysia, Mauritius, Singapore, and Taiwan, more than two-thirds of the family planning expenditures came from government sources, the other part coming from foreign aid, and private funds, and, in some countries, clients' fees. In other countries, Bangladesh, Bolivia, Tanzania, and Thailand, less than half of the amount derived from government funds.

As a percent of the health budget, family planning expenditures range from one percent or less in three of 16 developing countries for which data are

TABLE 8. Per Capita Expenditures on Family Planning

Annual per Capita Family Planning Funds in US Cents	Number of Countries	Countries
Under 10	3	Bolivia, Tanzania, Uganda
10 and under 15	1	Sri Lanka
15 and under 20	4	Bangladesh, Ghana, Hong Kong, Thailand
20 and under 30	4	India, Indonesia, Zimbabwe, Taiwan
30 and under 40	2	Dominican Republic, Pakistan
40 and under 50	2	Korea Rep., Tunisia
50 or more	8	El Salvador, Iran, Kenya, Malaysia, Mauritius, Philippines, Puerto Rico, Singapore

SOURCE: Dorothy Nortman and Ellen Hofstatter, Population and Family Planning Program: A Compendium of Data through 1978, 10th edition (A Population Council Factbook, 1980), Table 10, pp. 37-39.

FIGURE 2. Annual per Capita Funds for Family Planning Programmes, Selected Countries, Most Recent Estimate

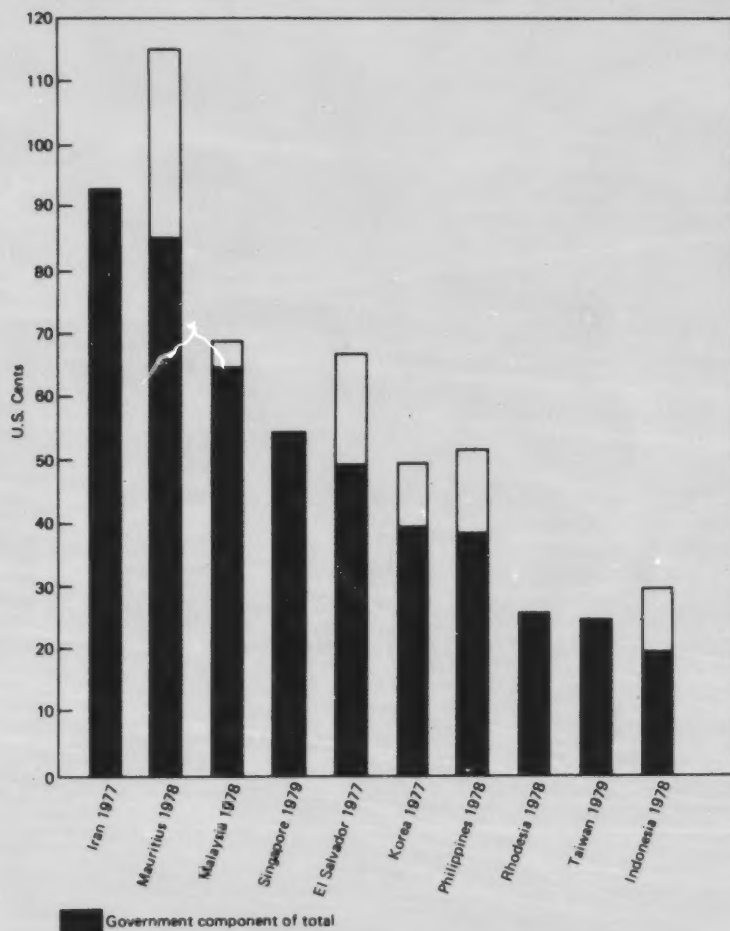
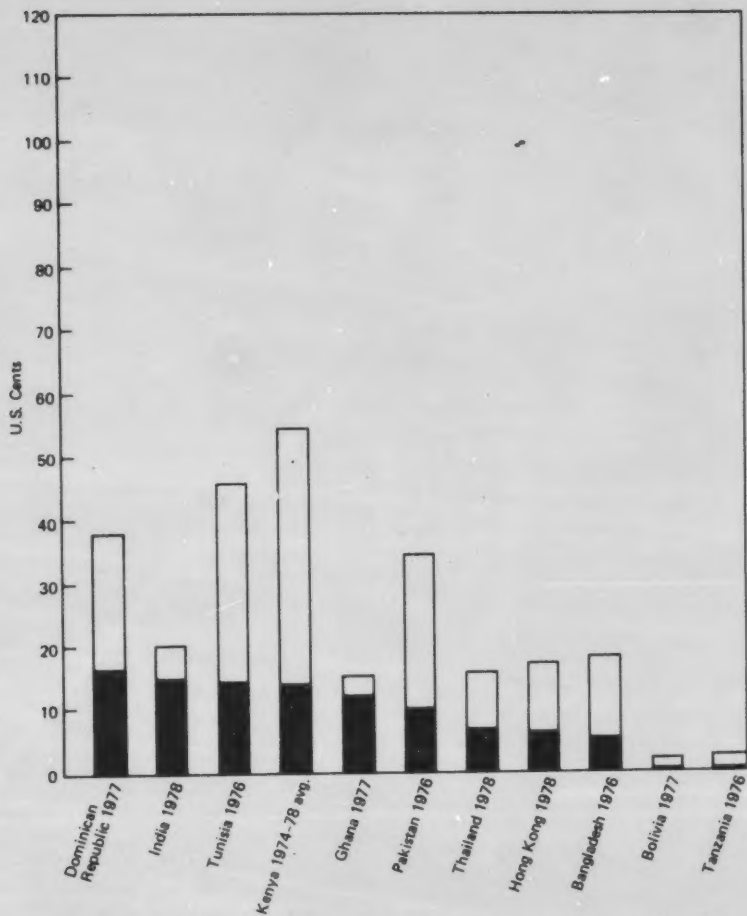


Figure 2 (cont'd)



Source: Dorothy Nortman and Ellen Hofstatter, *Population and Family Planning Programs: A Compendium of Data through 1978*, 10th edition, Table 10. (A Population Council Factbook, New York, 1980.)

available to 16 percent in Korea (1978), 23 percent in Indonesia (1978), and 45 percent in Bangladesh (1976), with a median of 7 percent. Health, in turn, generally receives a small share of the total government budget (five percent or less in 11 of 16 countries) so that the 36 cents per capita spent on family planning amounts to less than one-half of one percent of the overall national budget on the average.

It should be remembered, however, that the two most populous countries in the world, China and India, have allocated major national resources to their family planning programmes. Until recently, China financed the totality of its highly successful programme. India has consistently increased its national budget for family planning over time, and it rose from \$66 million in 1974 to \$101 million in 1978.

INTERNATIONAL ASSISTANCE TO FAMILY PLANNING

International financial support to population activities has grown from \$2 million in 1960 to \$190 million in 1971 to \$394 million in 1978, excluding double counting.* Table 9 provides a detailed analysis of international support to population activities between 1971 and 1978.

As Table 9 indicates, the largest donors, in order of the size of their contribution in 1978, the most recent year for which data are available, are the United States, Sweden, Norway, the Federal Republic of Germany, Japan, the United Kingdom, the Netherlands, and Canada. During the 1970's, the United States was by far the largest single contributor, although as other developed countries have increased their support, the relative contribution of the United States has declined.

*Annual flows of international population assistance totalled approximately \$656 million in 1978. These figures include transfers among donors. That is, governments contribute funds to the UNFPA, for example, which in turn distributes these funds to other United Nations agencies, non-governmental organisations, and developing country institutions. The United States Agency for International Development (AID) is the major contributor to the International Planned Parenthood Federation (IPPF) and Family Planning International Assistance (FPIA), and is a significant contributor to the Population Council, which also receives funding from other governments, the UNFPA and the Ford and Rockefeller

As a proportion of total development support, assistance to population activities increased from less than one percent in 1960 to 2.5 percent in 1971 and then declined to its current level of approximately 2 percent. Norway, Sweden, and the United States are the three countries which devote the highest percentage of their foreign aid to population activities.

Funding of population activities has followed an erratic course but has increased at a rate of between 10 percent and 20 percent per year since the mid-1960's. Between 1971 and 1975, funding increased approximately 13 percent annually. Since then, the pattern has been as follows: 1975-76, an increase of 8 percent (from \$281 million to \$304 million); 1976-77, an increase of 14 percent (from \$304 million to \$348 million), and 1977-78, an increase of 13 percent (from \$348 million to an estimated \$394 million).

The high rates of inflation prevailing throughout the 1970's significantly reduced the real value of the dollar flows to population activities. Eliminating double counting and adjusting for inflation (with 1970 as the base year), net international population assistance rose from \$162 million in 1971 to \$235 million in 1978, an increase of only 45 percent in constant dollars, compared to an increase of 134 percent in current dollars. International population assistance, corrected for inflation, is set forth in Figures 3 and 4.

There are significant differences in programmatic emphasis among donors. For example, the United States spends over 75 percent of its population resources in support of family planning programmes, while the comparable figure for Sweden is about 50 percent and for the UNFPA slightly less. About 19 percent of UNFPA resources supports basic data collection; the comparable figure for the United States is only around 9 percent and for Sweden is negligible. Both the United States and the UNFPA devote around 10 percent of their population assistance to the field of population dynamics. Biomedical research, including contraceptive development, receives over 40 percent of Sweden's population assistance, about 5 percent of the United States' population assistance and less than 1 percent of UNFPA resources.

Foundations. Each of these and similar transactions are included in the estimates of total assistance flows in Table 9.

TABLE 9. Population Assistance by Major Donors, 1971-1978 (thousands of US dollars)

	1971	1972	1973	1974	1975	1976	1977	1978
<u>Governments</u>								
Australia	-	357	579	639	1,587	967	1,345	3,021
Belgium	147	18	75	837	478	934	2,179	2,252
Canada	2,496	2,997	4,159	5,498	7,183	8,989	9,719	12,063
Denmark	1,918	2,289	2,035	4,784	3,548	4,978	4,445	7,722
Finland	507	892	1,033	2,587	2,026	1,578	1,745	498
German, Federal								
Republic of	1,657	2,435	4,392	5,770	13,400	8,739	14,434	17,002
Japan	2,080	2,196	2,812	5,293	7,971	9,000	11,000	15,743
Netherlands	1,106	2,232	3,718	5,785	6,695	8,954	9,649	12,083
New Zealand	-	77	40	580	880	607	573	627
Norway	3,870	5,539	8,600	10,800	18,500	27,400	30,000	39,962
Sweden	7,446	12,739	17,123	21,468	26,169	28,743	31,417	42,339
Switzerland	168	191	189	190	200	242	500	1,149
United Kingdom	2,311	3,257	3,861	3,032	6,450	6,983	10,866	14,062
United States ^{/1}	109,567	121,133	115,106	110,146	106,036	119,027	145,367	177,596
Others	1,283	1,592	1,747	2,325	3,580	11,356	3,918	2,562
Sub-total	134,566	157,944	165,469	179,734	204,701	238,497	277,157	348,681
<u>Intergovernmental Organisations</u>								
United Nations	6,995	5,952	8,459	20,786	24,234	28,009	22,705	20,000
UNICEF	2,382	2,371	3,711	5,753	6,725	6,611	6,700	6,700
UNFPA	8,937	19,840	34,684	57,000	71,213	75,781	72,131	95,699
ILO	165	989	2,259	3,827	4,901	6,483	6,775	3,717
FAO	607	574	1,370	1,539	2,238	1,400	1,400	2,500
UNESCO	38	28	2,554	4,130	5,337	4,042	5,034	4,700
WHO	2,823	9,830	15,991	18,932	22,979	29,234	34,879	38,200
World Bank ^{/1}	1,600	5,700	10,990	14,840	20,340	25,940	27,730	31,380
Others	5,200	6,577	1,789	6,225	6,300	6,300	6,500	7,000
Sub-total	28,747	51,861	81,807	133,032	164,267	183,890	183,654	209,896

	1971	1972	1973	1974	1975	1976	1977	1978
Non-Governmental Organisations								
Ford Foundation	21,261	18,864	15,149	14,791	10,586	11,315	10,352	10,000
IPPF/2	15,202	19,458	23,887	31,108	33,660	33,493	39,230	45,837
Population Council	16,397	16,667	16,128	15,582	12,076	11,000	11,302	12,624
Rockefeller Foundation	5,981	6,846	9,999	8,962	8,514	8,264	8,290	8,941
Family Planning International Assistance	276	948	1,774	2,560	3,274	4,471	7,871	12,351
Others	3,601	3,452	5,626	4,500	4,500	5,000	6,500	7,500
Sub-total	62,718	64,235	72,563	77,503	72,610	73,543	83,545	97,253
TOTALS	226,031	274,040	319,839	390,269	441,578	495,930	544,356	655,830
Total excluding double counting:/3								
a) in current US dollars	168,553	186,002	211,237	254,069	280,989	304,427	348,656	394,472
b) in constant US dollars	161,604	172,704	184,648	200,054	202,734	207,658	223,354	234,945

NOTES: All figures refer to calendar year.

/1 Except for USAID and the World Bank, data are expenditure. Annual estimates for USAID are commitments. Annual estimates for the World Bank are based upon its commitments according to loan or to credit agreements and the planned duration of project execution.

/2 IPPF data are of international grants.

/3 Arrived at by deducting the following from the total: Governments' contributions to UNFPA; USAID contributions to IPPF, Pathfinder Fund, FPIA and the Population Council; UNFPA contributions to organisations in the United Nations system; contributions from one foundation to another.

SOURCES: United Nations, "Report of the Administrative Committee on Co-ordination on Expenditure of the United Nations System in Relation to Programmes," *passim*; United Nations, Statistical Yearbook and Monthly Bulletin of Statistics; U.S. Consumer Price Index; Report on population assistance by the Organization for Economic Co-operation and Development; Governments' annual reports of development assistance agencies and organisation.

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FIGURE 3. International Population Assistance and per Capita Family Planning Assistance 1971-1978

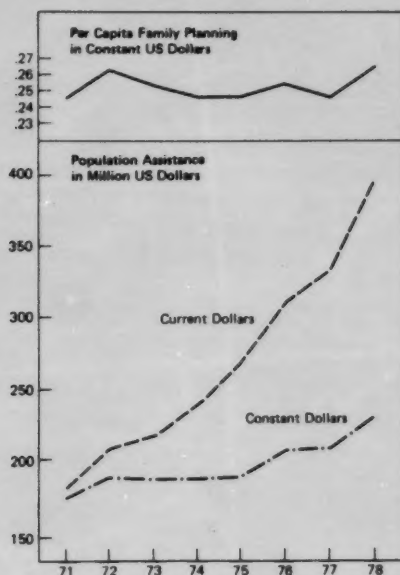
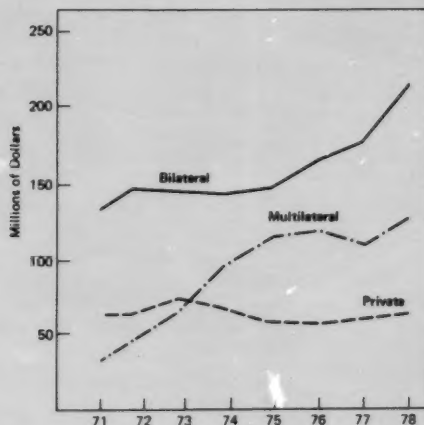


FIGURE 4. International Population Assistance by Type of Donor in Constant US Dollars 1971-1978



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Opening Addresses

His Excellency Soeharto
President of the Republic of Indonesia
Address at the Opening of the Conference
State Palace, Jakarta

First of all, I would like to extend my warmest welcome to Indonesia to all the Distinguished Delegates to the International Conference on Family Planning in the 1980's.

Furthermore, I would also like to express my highest appreciation for the confidence and honour bestowed upon our nation to host this Conference.

I consider the timing of this Conference as very appropriate, because we need to reevaluate our plans and endeavours in implementing family planning programmes carried out during the 1970's. Thus we will be able to continue to improve our efforts in the 1980's.

Actually we are all aware of the important meaning of family planning programmes for the future of all of us. Our future is really influenced very much by our success or failure in implementing family planning programmes, as this will fully determine our success or failure in carrying out the development of our society.

We are conscious--and for this reason we have held many international conferences--that the problem of implementing family planning programmes is not just a national problem of an individual country. We must, therefore, learn from each other and exchange our experiences. Our plans and efforts in the future must be based on our past experience.

Indonesia, as a country with such a big population, more than 147 million, is truly facing a great challenge in the field of population. Apart from such a big population, its distribution is also not proportional. The majority of our population lives on one of the relatively small islands, namely Java. We have no other choice, therefore, but to work hard in order to secure the success of our family planning programme. Otherwise, we will face an extremely critical population problem.

A big population does indeed constitute a great development potential. But we are also aware that a big population without the ability and possibility of heightening the people's prosperity, in fact,

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becomes a burden to society and it may cause disaster to successive generations.

For this reason, therefore, as far as we are concerned, the family planning programme is one of the extremely important national programmes. Taking into account the demands and capabilities of our society in the future, and also the challenges of our society's development, which will be even greater in the future, we must be able to accelerate the reduction of the birth rate for the sake of increased prosperity of the Indonesian people. To this end, we are striving very hard to curtail the fertility rate by 1990 to just about 50% of the 1971 level.

Our task and challenges in carrying out this family planning programme in the future are indeed not easy. But yet I am convinced, that the programme will continue to achieve encouraging results, because the people themselves realise that the success of the family planning programme is an essential key to the creation of a happy family.

As part of the community's life, it is obvious that the family planning programme does not stand alone. It affects various aspects of life, such as the education and culture of the people, the position and role of women in society, and so on. In this context, the aspect of education of the people is a highly significant factor. By enhancing the levels of people's education and knowledge, we hope that in the future, the implementation of family planning programmes will be facilitated. The people's advanced education will make the culturalisation process of the family planning concept easier. Therefore, our current problem--while we are improving the education and knowledge of our people--is to try to prevent the population growth rate from surpassing our nation's development growth rate. This is the great challenge we have to face in this decade of the 1980's.

I believe that some aspects of the problem we encounter in family planning are also similar to those of the developing countries in general. Therefore, since I signed the Declaration on World Population in 1967, Indonesia has always been active in various international conferences dealing with population and family planning problems. We would like to learn from the experiences of other nations. Such is the case during the present conference.

So far Indonesia has also been conducting many co-operative efforts and exchanges of experience with other nations, many in the framework of technical co-operation amongst the developing countries,

which we have felt to be of great benefit. Certainly such activities can be pursued further in the years to come.

Indeed, it is not an exaggeration if I mention here that the successful implementation of family planning programmes will be a key to the survival of the world in the future. More integrated concrete measures must therefore be adopted internationally.

Thus, it is the hope of all of us, that the experts attending this Conference will produce concrete formulations as the translation of the political commitment envisaged since the end of the 1960's, so that in the 1980's we can undertake more intense efforts in materialising the family planning programme.

It would be undoubtedly a great pleasure to us if the Distinguished Delegates to this Conference would spend some time in the field to see some of our family planning programme activities, so that the various shortcomings which we may have possibly overlooked can be indicated, in view of intensifying further the implementation of the family planning programme.

In conclusion, allow me to express my warmest congratulations and highest appreciation to the United Nations Fund for Population Activities, the International Planned Parenthood Federation and the Population Council which have organised this important International Conference on Family Planning, which, I am certain, will bring about great benefit to all of us.

I hereby declare the International Conference on Family Planning in the 1980's officially opened.

Jakarta, April 27, 1981.

Dr. Suwardjono Surjaningrat
Chairman, National Family Planning Co-ordinating
Board and President of the Conference
Report and Welcome Address
State Palace, Jakarta

Let me first of all heartily welcome you to this International Conference on Family Planning in the 1980's. You have come great distances from over 90 countries to participate in this meeting, directed to one of the greatest problems, and intended to help shape the future welfare of this planet.

In attendance here are very senior representatives including ministers and programme leaders, as well as representatives of international organisations, who together will determine the contribution of this conference to the decade ahead.

As you know, our Conference takes its place as one of the few international meetings directed to a worldwide review of experience and to global planning. The modern history of the field may be taken from 1952, when India established the first official government programme and both the IPPF and the Population Council were founded. It was 13 years later, in 1965, that the International Conference on Family Planning Programmes was held in Geneva with representatives from some 35 countries to consider the experience so far in action programmes and research projects. It was after another nine years, in 1974, that the Bucharest meeting was held: the first time governments had officially come together to debate population issues. Even though this conference was of a political nature it produced a World Population Plan of Action, and put the community of nations on record as recognising a broad series of population concerns and action goals. It also formalised the doctrine that the population field should serve development goals, and give the same attention to the fair distribution of benefits as had recently become prominent in other development activities. In the 7 years since then the various governments and international agencies have watched more closely for ways to integrate population programmes with other sectors, and we are still struggling to translate this into real action.

Notwithstanding those issues, from a global standpoint family planning programmes have continued to flourish. The overall prevalence of contraceptive use has risen dramatically in the past seven years, and fertility rates have clearly begun to

fall. Both of these trends have been notable here in the Asian region, and in Indonesia as well. In planning for this conference we felt that Indonesia, as the world's fifth largest country and with its location in Southeast Asia, reflected in many ways the essential situation of much of the developing world -- large populations, areas of very high density, high vital rates that have begun to fall but must still fall much further, severe health-related problems, and much yet to be done in the development context. Our programme here has developed in response to these general conditions, but also to unique features of the Indonesian setting.

The population and family planning programme here has, we believe been able to lay a strong foundation for the permanent institutionalisation of new behaviour and attitudes within our society. To carry this further during the decade of the 1980's, our activities will be oriented to accelerating outreach toward these goals in all their aspects, whether physical, social, cultural, economic, political, or legal.

We wish to do everything realistic, both within family planning and beyond family planning, that is appropriate to our society and especially to the village setting. The policy will continue to be to integrate the various programmes inter-sectorally, with a large latitude given to the community's own adaptations and initiatives. The stress will constantly be to advance the understanding of the benefits of the small family in relation to the quality of life. The form of the activities to be carried out will be not only the usual IEC work and contraceptive services, but also efforts to institutionalise family planning and at the same time to improve the income and welfare of the families of acceptors and of the groups in which they participate.

Finally, Ladies and Gentlemen, let me return to the theme of this Conference and to the challenges before us. On the average in developing countries over the next twenty years there will be a 60% increase in the childbearing age population. We seek this week to discover better ways to bring services of good quality, not only to the present unserved populations but to this drastically enlarged population as well. This is a concern of each of our respective nations but it is also a matter of global welfare. We are from over 90 countries, come together here because of a problem that is common to us all. This problem runs across every continent, every religion, every ideology and political system. It crosses all national borders. And unless the

people gathered together here can work on it effectively the job will not be done.

I hope that our Conference will be able to find ways and means to a wider commitment to population and family planning programmes and to discover community approaches which are suitable to the full development of the local society. Development, after all, is not merely physical but is mental and moral, and to attain it we need both a larger vision and a determined search for realistic action approaches.

Dr. Rafael M. Salas
Executive Director, United Nations Fund for
Population Activities
Family Planning in the 1980's: Requisite for the
Future
State Palace, Jakarta

I am delighted and honoured to be asked to address this Conference. It is the first time in more than fifteen years that such a Conference has been held and it comes at a very important time in the history of international concern with population issues.

The United Nations' latest estimates indicate that population growth is on a decline globally. This is a remarkable development when compared with the gloomy predictions of the past. And it is a tribute to all those men and women who have tirelessly worked for the last thirty years to bring information, advice and the means to regulate fertility to the people of the world and who have enhanced the social and economic development of nations. Conscious decisions on child spacing and family size have become a vital part of an international consensus on development goals and on the means of meeting them.

Experience has taught us that in population, more than in any other field of development, present actions must be defined by future needs. In order for us to have some workable conclusions at this Conference, it will be necessary for us to think strategically about the present and the future.

The first requisite is to extend our time perspective of the 80's to the next century. All development activities presuppose the achievement of an ultimate balance between population and resources and the environment which will have to support them. Our present cautious optimism over the decline of the population growth rate from two per cent in the sixties to the present 1.7 per cent and, hopefully, 1.5 per cent in the year 2000, is based on the experience of several decades of hard work. If this decline is to continue and stability is to be achieved in the middle of the twenty-first century, efforts from now up to that time must be continuous and sustained. We are talking of a future that can be realised only if today's activities come to fruition. This will require an equally deep commitment from us and our successors.

Second, among the many aspects of population programmes, it is important to give priority to the

management of family planning programmes. The technology of family planning has improved remarkably in the last twenty years. But as we know, there is much more to successful family planning programmes than technology. Programmes must be managed more efficiently and effectively. We must, therefore, endeavour to improve further our organisational and managerial capabilities to reach those couples who, as the World Fertility Survey indicated, are still in need of family planning services.

The third requisite is sensitivity to human values. Our gains and successes thus far have required of us the flexibility to adapt programmes to a variety of different local mixes of leadership, communication methods, facilities and attitudes. But dynamism and ability to innovate, as we have realised, are not enough. We have to be consistently sensitive to individual feelings and beliefs in addition. Let us be reminded at this point that increasing the scope of our work will require the positive decisions of millions of couples and continuous respect for individual values.

Fourth, there must be adequate resources for family planning programmes. The developing countries have adequately demonstrated in the past ten years that, with the proper amount of investment on their part in population programmes, they have been able to moderate population growth. The present need to provide adequate food, clothing and shelter for the 4.4 billion inhabitants on this planet underlies many of the structural difficulties the global economy is now facing. The projected addition of 2 billion more people by the turn of the century demands that, compared to other areas of international assistance, population programmes must be of the highest priority. External assistance is vital in specific areas to make national programmes more effective especially now that many of the developing countries have acquired the necessary conceptual and institutional and human resources to implement them comprehensively and effectively. We must, therefore, strive collectively to achieve the goal set by the International Conference of Parliamentarians in 1979 of one billion dollars of annual population assistance by 1984. This is a modest amount -- unable fully to meet even current demands and future needs.

Jakarta is a most fortunate choice as the site for this Conference. The Government of Indonesia's population programme, under the personal leadership of President Suharto and co-ordination of the BKKBN, has shown how a strong national policy, reinforced

by a widespread and responsive network in the communities, can gain the commitment and involvement of its citizens to achieve the spectacular acceptance of family planning and a consequent decline in fertility rates. It is an example of the commitment and effectiveness that we seek from this Conference.

We would like to thank President Suharto and the Government of Indonesia for hosting this Conference. And, like President Suharto, we will reach our goals firmly, step by step.

Dr. Carl Wahren
Secretary General, International Planned Parenthood
Federation
Address
State Palace, Jakarta

We approach the 80's with a delicate balance of promises and needs. The achievements of family planning programmes over the past two decades and the growing worldwide acceptance of fertility regulation as a normal part of community, family and individual life lead us to hope that we have a firm foundation for providing more and better services during the 80's.

At the same time, however, millions of people in the world have no, or limited, access to services. IPPF's survey of unmet needs shows that at least 400 million women are unprotected by contraception and are at risk of unwanted pregnancy. Many people still lack the information they require to make responsible decisions about parenthood. Others are deprived of the help they need in choosing and using contraceptive methods.

Indonesia has demonstrated that with a strong national policy and the full participation of the people much progress can be made. It is striking to study here how community forces can be engaged in the national effort through drawing non-governmental organisations into a real partnership with government.

It is in this same spirit of partnership that our three organisations have jointly sponsored this Conference. The United Nations Fund for Population Activities represents the initiatives of governments and inter-governmental support of national efforts; the Population Council represents the contribution of research and development to population and family planning; and my own organisation, the International Planned Parenthood Federation, represents the grass-roots involvement of the voluntary sector.

Since I represent the last of these three elements, it seems appropriate to dwell briefly on the reasons why the voluntary sector is so vital an ingredient for success, even in a situation where the government has fully committed itself to a population/family planning policy.

The first factor concerns credibility. National planned parenthood associations came into existence on the initiative of local people. Their indigenous

grass-roots membership provides a highly acceptable channel for community participation.

The second factor is continuity. National voluntary associations can sustain the provision of information and services at times when governments may have other pressing priorities.

The third factor is cost-effectiveness. Non-governmental organisations are able to call upon the efforts of scores of volunteers and thus engage the community in important forms of self-help.

Finally, voluntary organisations are in a position to take risks, and have the flexibility to encourage experimentation. This capacity has proved a valuable complement to governmental programmes.

The voluntary sector, therefore, is a partner in development, complementing, as here in Indonesia, the efforts of governments. Nowhere is this partnership more important than in ensuring the integrated approach to population and family planning which I feel, is the key to progress during the 80's.

Integration should take place at the highest policy-making levels as well as in the actual provision of services to the community. But I would like to suggest two additional aspects of integration which are not always fully appreciated. First, the integration of professional competence with human compassion so that our services are not only efficient, but are provided with the care and concern that makes them acceptable, indeed attractive, to individual users. Secondly, the integration of men and women in all aspects of family planning work. For years and years, this has been pointed out, but still family planning decisions at any level are seldom the result of a truly participatory process by both sexes.

Massive educational efforts are needed in order to achieve full integration as now defined; the people who are in positions to make this possible are ever changing and ever increasing.

I should like to conclude, Mr. President, by emphasising once again what I believe to be the two rationales of our work. First, the popular demand for family planning services has been overwhelmingly demonstrated. Second, the unfortunate fact that population growth adversely affects nearly every aspect of the development process and cancels out achievements attained by the most strenuous efforts.

Now it is up to governments, inter-governmental organisations and the private voluntary sector to redouble their efforts in joint partnership.

Mr. George Zeidenstein
President, The Population Council
Address
State Palace, Jakarta

It gives me an exceptional sense of hope to be here with you today. This International Conference on Family Planning in the 1980's represents the first such meeting since the Geneva Conference in 1965. With satisfaction, I note that the Population Council spearheaded the 1965 Conference and joins with UNFPA and IPPF as co-sponsor of this one. There are several reasons why I feel hope as this Conference commences. Whereas the 1965 Conference was held in Geneva, the present one is held in Jakarta--symbolic of the growing success of national family planning efforts. In 1965, only 18 governments of the developing world supported family planning programmes, today the corresponding number exceeds 85. In addition to governments, of course, the family planning associations grouped together in the International Planned Parenthood Federation support family planning programmes in all of these countries, and several more. Thus, we live today in a world in which there is wide recognition of the importance of organised programmes to provide contraceptive services and related information--in both the public and private sectors.

One of the principal reasons for holding a conference such as this is that it provides opportunities for us to learn from each other. We participants come from 90 countries and have a wide variety of experience in designing, implementing, and evaluating family planning programmes. We have experienced in many different ways the range of interactions that exist between family planning programmes and other sectoral efforts to foster economic growth and improve human welfare. This Conference also affords for all of us an opportunity, through our collective enthusiasm and solidarity, to rededicate and revitalise this centrally important sector of international development activities--the family planning programme sector.

In my opinion, a central element for achieving increasingly better results in the family planning programme sector is a greater awareness of the needs and experiences of contraceptive users in the provision of services. As we have learned from recent family planning programme experience in Bangladesh, more attention to the users' perspective can double

effectiveness. There, wider choices of methods, more highly trained local workers, intensive follow-up support and effective referral services for women who had accepted contraception, seemed to make the critical differences.

Many of the women who discontinue contraceptive use within the first year or two do so not out of any desire to become pregnant, but because of dissatisfaction with available methods and services. We can hope that in the future, science will supply us with better contraceptives and, indeed, one of the important priorities of the Population Council is its effort to develop contraceptives that are safer, more effective, and more convenient--and to encourage similar efforts on a worldwide basis. But hope in that regard does nothing to eliminate the disappointments being experienced right now. Operations research and program evaluation need to test how best to make changes that do not excessively encumber family planning programmes but that do take more adequate account of the perspective of users. The effort, of course, should not be to break down family planning structures that have been created at great expense and effort, it should be to illuminate programmes with additional awareness and responsiveness. Our family planning programmes should be both vehicles for and beneficiaries of the positive social changes in their environments.

Given the nature of the contraceptives now available, family planning programmes provide services mainly to women. Therefore, we can expect that performance will be improved when family planning programmes are better integrated into existing communications networks among women. There continues to be a notable scarcity of women among the decision-making officials of family planning programmes. Yet it stands to reason that women are much more likely than men to be aware of problems experienced by female users of contraceptives, and more effective than men as personifications of family planning ideas.

The only way to overcome this problem is to engage in what is called affirmative action by actively seeking out, recruiting, training, and developing potential women administrators and leaders. The imbalance of the genders will not correct itself through natural evolution alone, but only through active intervention and effort. I submit that the effort is worthwhile: it will bring us even closer to an understanding of the users' perspective.

With this perspective in mind, we ask ourselves at this Conference--how can we improve the perform-

ance of family planning programmes? How can we devise programmes that better serve people's needs and reach more effectively into rural areas and the poorer sections of the cities? How can we provide levels of quality in the services we deliver that will translate into substantially more sustained use of contraception over time? And how can we, at the same time, have the nationally desired impacts on reducing fertility?

We have assembled here in Jakarta the foremost experts in the field. It is our task in the days ahead to explore these questions as we chart the course of family planning in the '80's, and beyond.

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